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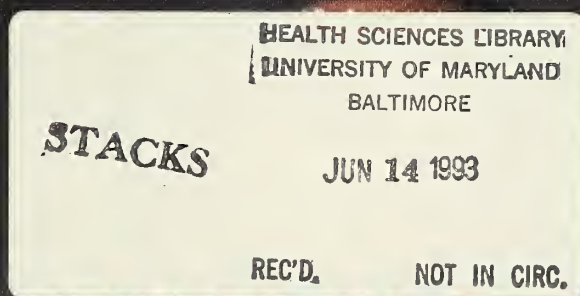




# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 90 Number 1

June 1993



Arkansas Medical Society President,  
Glen F. Baker, M.D.,  
and his wife Dorotha Baker



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*Our Cover:* Annually from 1893 to 1919, the Arkansas Medical Society presented a gold medal to the graduating medical student with "the best examination in all branches of study." In 1905, Dr. Orange King Judd won the medal shown on the cover. The original medal may be seen in the Robert Watson History of Medicine Room at the UAMS Library. This information was provided by the Historical Research Center, UAMS Library. Photo taken by Mike Dupslaff, Campus Media Services Department, UAMS.



# New Approaches

William E. Golden, M.D.\*

April marked the beginning of a new philosophy in the approach to quality improvement by the PRO program and the Arkansas Foundation for Medical Care. Embodied in the regulations of the Fourth Scope of Work, the new program focuses more on assessment of communitywide practice patterns and educational feedback to the provider community. While case review and provider profiling will continue on a smaller scale, the predominant tone of the Fourth Scope of Work is the promotion of local initiatives and provider cooperation in a statewide quality improvement effort.

For years the provider community has had its misgivings about the mechanisms by which Medicare structured its quality assurance and utilization review programs. The majority of previous activities dwelled on preprocedure review and ongoing random chart audits whose consistency and validity were challenged. While few would argue that the Medicare program should have no mechanisms of service assessment, many questioned whether the final outcome of traditional PRO review warranted the extensive nature of daily ongoing operations.

In response to many of these concerns, the Health Care Financing Administration has embarked upon a new approach to quality improvement and surveillance. The core of this program is the Health Care Quality Improvement Initiative (HCQII) which espouses an educational as opposed to punitive approach to quality improvement. The new methodology emphasizes pattern analysis of aggregate provider data, assessment of the data by study groups, and educational feedback programs to providers of the recommendations of these study committees. In short, the Fourth Scope of Work offers the provider community an opportunity to work with the PRO to establish local quality

improvement activities which would benefit their home institutions and patient constituencies.

How does pattern analysis work? The Arkansas Foundation for Medical Care now has in Fort Smith a high speed desk top computer with five gigabytes of hard disk storage. This computer memory houses databases derived from claims data of 300,000 Medicare hospital discharges in Arkansas since 1989. The Fourth Scope of Work enabled the AFMC to hire a biostatistician, Mario Cleves, Ph.D., to apply special database statistical packages to abstract information from these stored records and analyze patterns of care in the state. Leading the HCQII team is the Clinical Coordinator, William E. Golden, M.D., who reviews existing data to generate questions and information needs from this repository of recent statewide clinical activity. The work of the HCQII team is guided by national, modeled data provided by HCFA that examines mortality in every state in the country. The data examine one hospitalization per Medicare beneficiary who was hospitalized during the course of a calendar year. The raw mortality rate is adjusted for several conditions by a variety of comorbidities identified from claims data. The model data have been sent to area hospitals in the form of the annual mortality report. It identifies an observed mortality rate for certain medical conditions and procedures as well as the predicted mortality rate given the coexistent comorbidities that are included in the model.

HCQII personnel review this material and target issues for further exploration. Data can be examined from the perspective of statewide information, hospital bed size clusters, and individual hospital performance. When an issue appears to warrant further study, the HCQII team can develop a project, assemble a study group of practicing physicians, pull chart data to analyze clinical trends and, conduct further research on educational programs in response to generated information. The PRO will establish a master advisory com-

\* Dr. William E. Golden is Clinical Coordinator for the Arkansas Foundation for Medical Care and Associate Professor of Medicine, University of Arkansas for Medical Sciences.

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Cover photo by LeAnne Rogers, AMS staff member.



# Tobaccics - A Doomed Generation

David S. Bachman, M.D.\*

**T**he winds of change concerning knowledge of tobacco's ills have blown with unremitting fury in recent years.

What began as a trickle of information concerning health eroding effects of tobacco leaf use now blows with gale-like force - hardly a day goes by when one does not see or hear of a new scientific study reporting on the health eroding effects of tobacco use.

Much time and writing has been devoted to the publishing of these scientific findings.

Little space is given to the manner in which today's tobacco users are reacting to the demise of the tobacco empire by our health forces.

It is that topic I wish to address:

Tobacco use was a happy, carefree every day "cheap luxury" in the early and middle years of this century. "Everybody" did it, it was the "in" thing - a socially acceptable lifestyle for rich and poor alike.

A storm warning appeared in the early nineteen fifty's - some researcher produced cancer on the skin of mice by painting tobacco tar on their backs.

The reaction from the smokers? - "Some crazy nut spends his time painting that stuff on a mouse - we're not mice; so, why worry."

Little did they realize a mouse's skin is similar to the lining of the air passages of our lungs. Had this been understood, that scientific finding would have chilled even the staunchest of tobacco supporters.

Since Dr. Wynder's "skin painting tar job", the world has seen over 50,000 scientific articles attesting to tobacco's dangers.

The tobacco industry has responded with no plausible counter scientific studies - only denial after denial.

One might compare this paradox to seeing a flight

of thousands of geese flying North and one solitary contrarian heading South.

Despite tons of scientific study, our Government refuses to pass legislation protecting the American people from second hand tobacco smoke and "hand-cuffs" government agencies set up to regulate the tobacco industry.

Were those agencies granted such authority, the tobacco industry would be shut down for dispersing a product (tobacco) unsafe and unfit for human or animal consumption.

Tobacco users of today are cognizant of the above. One sees change in their attitudes.

The once carefree tobacco users are worried, harrowed and uneasy. They fully realize that smoking, in reality, is a death style - tomorrow's slaughter line in which they are part of - a chilling, disquieting thought.

Their faith in that multi-billion dollar industry is wavering.

"Yesterday" the answer to the question, "Do you ever think of becoming a non-smoker?", was, "Hell no, it's fun and I enjoy it! You gotta be crazy man!"

Today, the oft heard answer to that question is, "I know I should stop - I just haven't gotten around to it yet."

Are they willing to do something about their tobacco addiction? Slowly but surely they are seeking professional help in ridding themselves of the worst addiction known to mankind.

The nicotine patch, behavior modification programs and a continuing support group similar to Alcoholics Anonymous offers hope and salvation for combatting this life long addiction.

Not in my lifetime, but perhaps in my son's, there will be a smokeless, tobaccoless generation - people who will look back in dismay at the number of people who committed suicide via Lady Nicotine.

Pity the "tobaccics" of today - a doomed generation.

\* Dr. Bachman, now retired, practiced as a general surgeon and brochoesophagologist at the Millard-Henry Clinic in Russellville for 20 years.

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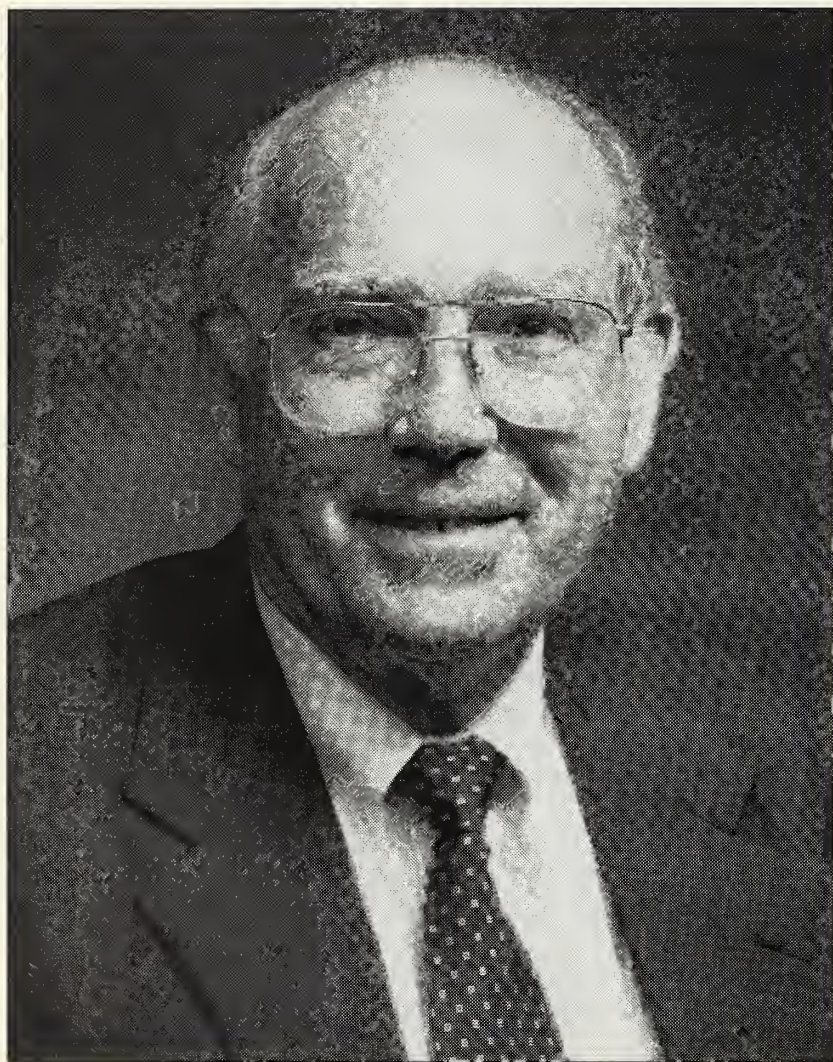
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# A HEALTHY OUTLOOK.



*Dr. Glen Baker, Director of Laboratories, Arkansas Children's Hospital  
President, Arkansas Medical Society*

*W*orthen National Bank is pleased to welcome Dr. Glen Baker as a member of its Board of Directors. In addition to serving as director of laboratories for Arkansas Children's Hospital, he is professor and executive vice-chairman of the Department of Pathology at University of Arkansas School of Medicine. In 1990, Dr. Baker became director of blood services for the Little Rock Chapter of the American Red Cross. Dr. Baker's significant contributions to the community and to the health care profession will make him an important member of the Worthen team.





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Volume 90 Number 6

November 1993

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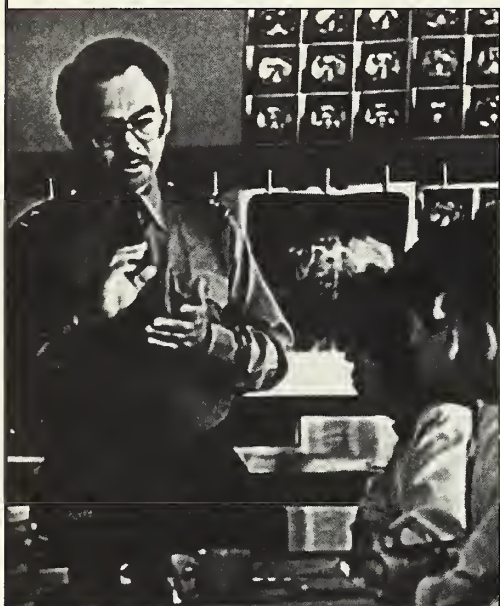
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# **ARKANSAS MEDICAL SOCIETY 118TH ANNUAL SESSION**



**"THE BASES ARE LOADED . . .  
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**Excelsior Hotel/Statehouse Convention Center**

**Little Rock, Arkansas    April 7 - 9, 1994**

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MICHAEL F. STALEY  
"ARSONIST OF THE MIND"**

Award winning Fire Fighter and EMT Mike Staley will be our keynote speaker at 5:00 p.m. Mike leaped to the aid an injured driver at the Daytona International Speedway at the infamous Calamity Corner in 1990. Another race car careened out of control and hit Mike at 160 miles per hour and his life has never been the same. Footage of the accident made television news around the world and was featured on "Rescue 911." His story will impact you with its humor, honesty and power as he tells you "Ten Things Your Patients Never Told You." The speaker is sponsored by Freemyer Collection System.

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Clinic managers are welcome and encouraged to participate in all activities of the AMS Annual Session. The registration fee for clinic managers is \$75. A special prize for clinic managers will be given away during exhibit hours on Thursday, April 7, 1994. The Society will have over 75 companies exhibiting their products or services, including insurance, pharmaceuticals, billing and collecting, computer software and financial information. The feature sessions will contain timely information on health care reform that will be beneficial to practice management.



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# ARKANSAS MEDICAL SOCIETY 118TH ANNUAL SESSION

## “THE BASES ARE LOADED . . . AMS’ AT BAT”



### Statistics: Alice G. Gosfield

Alice G. Gosfield practices law primarily in Philadelphia, Pennsylvania, and is also 'of counsel' for a law firm in Kansas City, Missouri. Ms. Gosfield has restricted her practice to health law and health care regulation since 1973, with a special emphasis on non-institutional reimbursement, medical staff issues, utilization management and quality assurance, fraud and abuse and peer review. A graduate of Barnard College and NYU Law School, she served as President of the National Health Lawyers Association from 1992-1993.

Ms. Gosfield has served on three committees of the National Academy of Sciences Institute of Medicine studying issues in utilization management and clinical guidelines and has consulted to the federal Agency for Health Care Policy and Research.

She publishes and lectures frequently on health law issues for groups including the American Medical Association, Medical Group Management Association, Group Health Association of America and American Bar Association.

She is on several periodical editorial boards including Medical Economics and is the consulting editor for Clark Boardman Callaghan's health law series and contributing editor for their annual Health Law Handbook. She has been listed repeatedly in The Best Lawyers in America (Health Law) and is a member of the American Medical Association's Consulting Network.

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**Alice G. Gosfield**

*-- Friday, April 8, 1994 11:00 a.m.*

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- \*Shufflefield Lecture & Luncheon*
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- \*Entertainment*



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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 90 Number 11

April 1994

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Cover photo was taken by AMS member M.C. Milligan, M.D., a retired physician from Pine Bluff.

# An Ounce of Prevention

Ben N. Saltzman, M.D.\*

Many years ago as a young physician just out of the Army of World War II and in general practice in Mountain Home, Arkansas, I found myself busily engaged in the care and treatment of more illnesses than I felt I could successfully manage. I wondered why there was so much sickness in so small a community. Visiting with colleagues during meetings of the state medical society, I learned that others were experiencing the same sense of overload.

About the same time, I was invited to become a member of the Arkansas Tuberculosis Association Board of Directors. Here I learned that we were dealing with a greater problem than mine on a state and national level. Not long afterwards, the National Tuberculosis Association brought forth a logo that simply stated, "Prevention is the Cure." We were now using drugs that could successfully treat tuberculosis, but the concept of preventing tuberculosis by the use of early prophylaxis appealed to all of us. Recently, of course, there has been a resurgence of the disease, probably because we have forgotten to apply the preventive measures we have on hand.

There are other problems that cry for corrective preventive measures. The American Academy of Family Physicians in cooperation with the National Highway Safety Administration has been promoting the use of automobile equipment for young and old alike. The Academy has persistently sought the aid of the family physician to teach parents how to save the lives of their children as well as their own lives. This began with the introduction of child safety seats and the use of seat belts in our cars.

Recently, I was informed by the Academy that February 13-19, 1994 had been designated as "National

Child Passenger Safety Awareness Week." The week has now passed, but a proclamation that accompanied the designation bears repetition;

WHEREAS February 13-19, 1994 has been declared Child Passenger Safety Awareness Week;

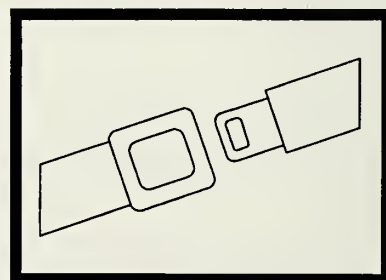
WHEREAS more children in the United States are killed and crippled in car crashes than from any other cause of injury;

WHEREAS when correctly used, child safety seats are 71 percent effective in preventing fatalities and 67 percent effective in preventing serious injury;

WHEREAS 268 children age four and under were saved in 1992 by child passenger safety seats, and 2,061 lives were saved by child restraint use from 1982 to 1992;

WHEREAS if child safety seats were used by all children under age five, an estimated 50,000 serious injuries would be prevented and 455 lives would be saved each year;

WHEREAS all 50 states, the District of Columbia, Puerto Rico and the U.S. Territories have enacted laws requiring the use of child passenger protection systems;



\* Ben N. Saltzman, M.D., is a retired family practitioner from Mountain Home, Arkansas.



Arkansas Medical Society

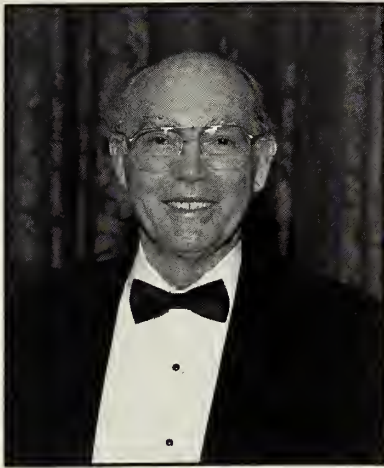
# "ON THE RIGHT TRACK"



117TH ANNUAL SESSION • APRIL 15 - 17, 1993  
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## Inaugural Address

**Glen F. Baker, M.D.**  
**President 1993-1994**

Dr. Lawson, colleagues, family and friends: we as professionals receive few honors from our peers during our professional life. To be asked to serve as President of the Arkansas Medical Society is, indeed, a centinel event in my life and I thank you for this honor.

My professional career is no different than many of yours. I, like you, have a support group, always in the background, giving not only of time but indulgence, tolerance and, most of all, love. Without that support from my family and friends, I would not be standing here this evening.

I am very happy to share this event with my wife, Dorothea, my son, LeMon Baker, and his wife, Darlene, of Jonesboro; my daughter, Connie Melton, and grandson, Geoffrey Melton, of Texarkana, Texas; our friend and guest, Michael Craven, and his daughter, Cara, also of Texarkana, Texas.

When one begins introducing friends, he is frequently embarrassed to find that, in the excitement of the moment, he has overlooked someone important to him. I do not wish to make that mistake, however, I do want to recognize four special people. These individuals have been part of my professional career for many years and very close family friends for an equal number of years: Dr. Don Vollman and his wife, Mary, of Jonesboro, and Dr. Joe T. Wilson and his wife, Gail, also of Jonesboro. Thank you for your friendship.

It is traditional for the incoming president to give an inaugural address. I will not break that tradition. Many of you know, however, that I prefer action over words.

I have learned a few things during my years of affiliation with and participation in medical education. One should say what he intends to say in an organized and succinct manner in a short period of time, then devote the remainder of time responding to questions and a more in-depth discussion of those questions.

I will be short and pledge to devote the entire year of my Presidency for the betterment of the Arkansas Medical Society.

The theme of this year's annual session is entitled "ON THE RIGHT TRACK". What could be a more appropriate title for an inaugural address?

Ask yourself, are we, as an Association, postured to represent our membership in the healthcare environment we currently find ourselves in? ARE we on the right track?

We have bylaws, rules, a committee structure and a governmental affairs initiative. Will this be sufficient to meet the Association's needs during this period of healthcare reform?

We, as an Association, react to situations. On occasion, we have been pro-active. For example, the Association's lawsuit against the Department of Health and Human Services. Are we postured to react as quickly in this rapidly changing, highly charged environment? Can we react to, and do we have a structure that will allow us to, represent our membership in the environment of managed care, managed competition, global payment, expenditure limits, practice guidelines? More importantly, will our membership allow us to develop an action plan to respond to these challenges? I have some concerns about the latter. I suggest that we stop for a moment and look around at those in attendance this evening. Also, try to remember those in attendance during this annual session. The number is small.

A few years ago I was asked to chair the Annual Session Committee. I attempted to approach this new responsibility in a programmatic manner by reviewing past records of the annual session. I found that attendance was almost always the same every year - 250-300 individuals, almost always the same physicians, and

over two-thirds were serving in some official capacity as a delegate or committee member.

We, as an Association, can't face the challenge before us with 300 participating members. It will require the entire membership's ACTIVE participation if we are to survive in this current environment.

A start was made in December when Dr. Lawson called for a leadership meeting of all specialty groups. We must continue this activity and expand our efforts to bring the membership together. We then can become a force to be dealt with, but only then.

We have been successful in diverting or defeating healthcare legislation that the Council of the Arkansas Medical Society did not believe in the best interest of the patient or the medical community. We need to continue this effort and intensify it. My concern, however, is that action in this arena is now at the national level. We, as a State Association, will have much less influence on policy. New policy will be developed at the national level and transmitted to the State level for implementation.

What are our options? Is there an action plan that we can develop? Is there a plan that gives us some reasonable assurance of having input in the delivery of healthcare, in the reimbursement system? I think there is.

It came to me recently that we, as an Association, attacked the problem of Worker's Compensation reimbursement. We approached that issue in a very aggressive manner and were successful in developing a fee schedule that was acceptable to all parties. This was successful due to the efforts of the staff of this Association and several members of the Council. We assumed that we had the authority to negotiate on behalf of the membership, however, we did not ask for a mandate from them.

*Double talk artist Eloise Hope posing as "Dr. Meredith".*



What can we do? I believe we need to start an initiative to address healthcare reform. Many state legislatures have already begun developing plans. Florida, Pennsylvania, North Carolina, and Washington are developing their own managed competition plans. Hospital groups are doing the same thing. I am certain that the health insurance industry is actively involved in developing an action plan in response to healthcare initiatives developing at the national level.

If we fail to act and act soon, we will be left without options, without influence and without a base to negotiate.

I believe it is time for the Council of the Arkansas Medical Society to identify a working committee to address this issue. The American Medical Association does have in place a support system for State Associations to assist in the state health system reform arena. I will propose to the Council of the Arkansas Medical Society that we ask this group for assistance.

If I wished to be bold, I might state that I think it is time we developed a new entity of the Arkansas Medical Society; a subsidiary that will bypass the anti-trust issue and serve as a negotiating vehicle for managed care contracts. This body could have many negotiating units representing each of the specialty divisions. A statewide IPA. I realize that this may seem radical, but I believe the situation we find ourselves in calls for radical action. I do not stand here and recommend that this be the vehicle we develop, I simply use it to make the point that I believe we are extremely vulnerable and, if we do not develop an aggressive plan before the year is out, medicine in Arkansas will be on comfort care.

Our profession and the manner in which we practice medicine will not survive as we know it. Dr. Clowe, the AMA President, in a speech to the Orange County, California Medical Society, stated, I quote, that "the AMA favors total reform of the nation's healthcare system as long as that reform includes cost containment and places the patient first. Managed competition seems to be the most workable alternative for system reform. It MUST be managed, not controlled. Cutting administrative red tape, forcing insurance reform, slashing the cost of defensive medicine, and eliminating inappropriate care are essential to total system reform." I think all of us agree with that statement. My concern is that we will not be listened to or allowed to assist in developing this new healthcare system.

As your new President, I pledge to devote maximum energies to this cause.

I issue a challenge to each of you to return home and insist that your respective County Medical Society begin bringing the membership together - not the regular participants, but the TOTAL membership - a grassroots effort.

I will present to the Council a request to develop a team of informed individuals to assist you in bringing



this message to the membership. If town meetings are good enough for the "Billary Administration" it should be adequate to meet OUR needs.

It is absolutely essential if we are to survive that the membership come together as a cohesive group with one voice - it is our only chance for survival.

Each of us, whatever our specialty, has developed a response to the multiple constraints placed upon us by federal government over the past several years. I have faith that we can respond to the challenge we now face.

We must take the position that we are responsible for the delivery of healthcare, we are responsible to our patients. We must protect them. We know about access, we know about technology, we know about family demands, we know about patient abuse of the system, we know about provider abuse of the system. Who better to provide input into a newly designed healthcare delivery system and its application.

I apologize if I have come across as an evangelist. It should be obvious to all of you that I feel very strongly about the role we in organized medicine of Arkansas should play. I cannot assume the Presidency of the Arkansas Medical Society without expressing to you my concerns about this issue. We have an obligation to our patients and, the citizens of the state of Arkansas.

I ask that each of you reflect upon my position and pledge your support.

Thank you.



*Art Porter at the President's Reception.*

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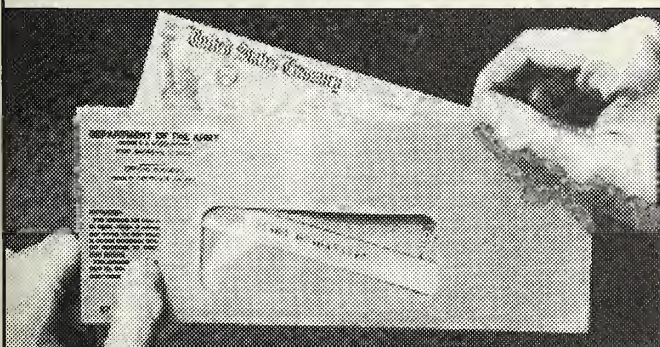
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# 1993 Arkansas Medical Society Annual Session

	<b>Officers</b>	<b>First Session</b>	<b>Second Session</b>
Speaker	John Crenshaw	present	present
Vice Speaker	Brenda Powell	present	present
President	J. Larry Lawson	present	present
President-elect	Glen F. Baker	present	present
Vice President	Steve Schoettle	-	present
Secretary	Charles Rodgers	present	present
Treasurer	Lloyd Langston	-	present

	<b>Councilors</b>		
District 1	Merrill Osborne	-	present
	Dwight Williams	-	-
District 2	Lloyd Bess	present	-
	Michael Moody	present	present
District 3	Hoy Speer	-	-
	Samuel McGuire	-	-
District 4	Anna T. Ridling	present	present
	Paul Wallick	present	present
District 5	Wayne Elliott	present	-
	Robert Nunnally	present	present
District 6	F. E. Joyce	-	-
	James Armstrong	present	present
District 7	Thomas Hollis	present	present
	Ronald Bracken	present	present
District 8	David Barclay	-	-
	Joseph Beck	present	-
	Paul Cornell	-	-
	William Jones	present	present
	Charles Logan	present	present
	R. Jerry Mann	present	present
	Harold Purdy	present	-
District 9	Robert Langston	present	present
	David Rogers	-	-
	Janet Titus	-	-

	<b>Councilors</b>	<b>First Session</b>	<b>Second Session</b>
District 10	Gerald Stolz	present	present
	Paul Wills	-	-
	Morton C. Wilson	-	present

	<b>Past Presidents</b>		
1979-1980	A. E. Andrews	present	present
1971-1972	C. Stanley Applegate	-	-
1985-1986	John P. Burge	-	present
1983-1984	Asa A. Crow	present	present
1964-1965	C. Randolph Ellis	present	present
1969-1970	Ross E. Fowler	present	-
1951-1952	Charles R. Henry, Sr.	-	-
1982-1983	Morriss M. Henry	-	-
1988-1989	John M. Hestir	present	present
1990-1991	William N. Jones	present	present
1987-1988	W. Ray Jouett	present	-
1976-1977	Albert S. Koenig, Jr.	present	present
1977-1978	W. Payton Kolb	present	present
1980-1981	Kemal E. Kutait	-	-
1986-1987	Ken Lilly	-	-
1967-1968	Joseph A. Norton	-	-
1974-1975	Ben N. Saltzman	present	present
1981-1982	Purcell Smith, Jr.	-	-
1968-1969	H. W. Thomas	-	-
1975-1976	T. E. Townsend	-	-
1963-1964	Joe Verser	-	-
1991-1992	George Warren	present	present
1972-1973	C. Robert Watson	-	-
1989-1990	James R. Weber	present	present
1984-1985	Charles F. Wilkins, Jr.	-	present
1973-1974	John P. Wood	-	-
1978-1979	George F. Wynne	-	-

## House of Delegates Composition

	<b>Delegates</b>	<b>First Session</b>	<b>Second Session</b>
Arkansas (1)	NOT REPRESENTED	-	-
Ashley (1)	NOT REPRESENTED	-	-
Baxter (2)	Robert Baker	present	present
	Peter MacKercher	-	-
Benton (3)	Barry Allen	-	present
	William Summerlin	-	present
Boone (1)	Carlton Chambers	present	present
Bradley (1)	Joe H. Wharton	-	-
Carroll (1)	Oliver Wallace	present	present
Chicot (1)	NOT REPRESENTED	-	-
Clark (1)	Noland H. Hagood	-	-
Cleburne (1)	Lee Vaughn	-	-
Columbia (1)	Scott McMahan	-	-
Conway (1)	NOT REPRESENTED	-	-
Craighead/ Poinsett (6)	R. Duke Jennings	present	-
	David Silas	-	-
	Joe Stallings	present	present
	Don Vollman	present	present
	Joe Wilson	present	present

	<b>Delegates</b>	<b>First Session</b>	<b>Second Session</b>
Crawford (1)	NOT REPRESENTED	-	-
Crittenden (1)	G. Edward Bryant	-	-
Cross (1)	NOT REPRESENTED	-	-
Dallas (1)	Don Howard	-	-
Desha (1)	Howard R. Harris	-	-
Drew (1)	NOT REPRESENTED	-	-
Faulkner (1)	J. J. Magie	present	-
Franklin (1)	David Gibbons	present	present
Garland (5)	Marshall Handleman	-	-
	Naomal Jayasundera	-	present
	Gopakumar Maruthur	present	present
	Robert McCrary	present	present
	Timothy Webb	-	-
Grant (1)	Clyde D. Paulk	-	-
Greene/Clay (1)	Roger E. Cagle	present	present
Hempstead (1)	Lowell O. Harris	-	-
Hot Spring (1)	C. R. Ellis	present	-
Howard/Pike (1)	Joe King	-	-



# House of Delegates Composition (cont'd)

	Delegates	First Session	Second Session
Independence (2)	William Waldrip	present	present
	John R. Baker	present	present
Jackson (1)	J. D. Ashley	-	present
Jefferson (4)	Simmie Armstrong	-	present
	Sue Frigon	-	present
	John Lytle	present	present
	David Jacks	-	present
Johnson (1)	Donald Pennington	-	-
Lafayette (1)	Sanford E. Hutson	present	-
Lawrence (1)	Robert Quevillion	-	present
Lee (1)	Duong Ly	-	-
Little River (1)	Joe G. Shelton	-	-
Logan (1)	John R. Williams	-	-
Monroe (1)	Jerry C. Chapman	-	-
Miller (3)	John A. Gillean	-	present
	Joseph R. Robbins	present	-
	Herbert B. Wren	present	-
Mississippi (1)	Joe V. Jones	present	present
Monroe (1)	N. C. David	-	-
Nevada (1)	NOT REPRESENTED	-	-
Ouachita (1)	William Dedman	present	present
Phillips (1)	P. Vasudevan	-	present
Polk (1)	David Fried	present	present
Pope (2)	Rick Harrison	present	present
	Kevin Beavers	present	-
	James Kolb	present	-
Pulaski (32)	D. B. Allen	-	present
	Raymond Biondo	present	-
	Amail Chudy	present	present
	Bob E. Cogburn	-	-
	Claudia Davis	-	-
	Phillip Deer, III	-	-
	Kurt Dilday	present	-
	Marlon Doucet	-	-
	Jim English	-	present
	Charles P. Fitzgerald	-	-
	A. Tharp Gillespie	-	-
	William E. Golden	-	-
	Edwin Hankins, III	-	-
	Fred O. Henker	present	present
	C. Reid Henry	-	-
	Tom Jansen	-	-
	Anthony D. Johnson	-	-
	Carl L. Johnson	-	-
	David King	-	-
	Marvin Leibovich	present	present
	Gail McCracken	-	-
	Fred G. Nagel	-	-
	George A. Norton	-	-
	J. Mayne Parker	present	present
	Carl J. Raque	-	-
	John F. Redman	-	present
	Ashley S. Ross	-	-
	Ted Saer	-	present
	Bruce E. Schratz	-	-
	Frank M. Sipes	present	-
	William L. Steele	-	-
	Robert G. Valentine, Jr.	-	-
	Samuel Welch	-	-
	John L. Wilson	present	-
	Paul W. Zelnick	-	-

	Delegates	First Session	Second Session
Randolph (1)	NOT REPRESENTED	-	-
Saline (1)	Marvin Kirk	present	present
Sebastian (9)	Randy Ennen	-	-
	R. Cole Goodman	-	-
	David Kocher	-	-
	John R. Swicegood	present	present
	William Schemel	-	-
	John H. Wikman	-	-
	John D. Wells	-	-
	Carl L. Williams	-	-
Sevier (1)	Mike Buffington	present	present
St. Francis (1)	Samuel A. McGuire	present	-
Tri-County (1)	Griffin Arnold	-	present
Union (2)	Gary Bevill	-	-
	Allan Pirnique	present	present
Van Buren (1)	John A. Hall	-	-
Washington (6)	Curtis Hedberg	-	present
	Anthony Hui	-	present
	William McGowan	-	present
	William B. Nowlin	-	present
	Terry J. Ortego	-	present
White (2)	Jim Citty	-	present
	William White	present	present
Woodruff (1)	James E. Rowe	-	-
Yell (1)	James L. Maupin	present	-
Medical			
Student (1)	Amanda Ferrell	-	present
Resident (1)	NOT REPRESENTED	-	-





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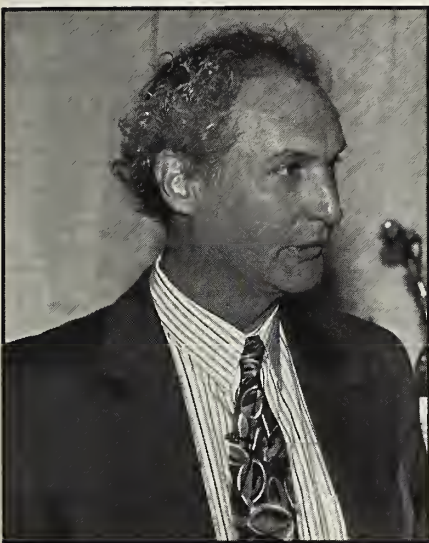
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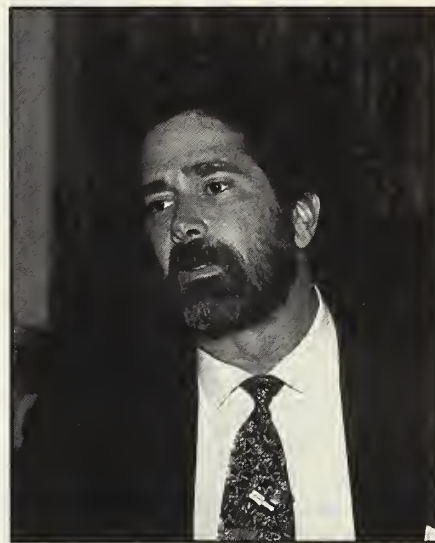
# 1993 Annual Session Speakers



**Carl Hammerschlag, M.D.**, a practicing psychiatrist and a faculty member at the University of Arizona Medical School, with a regular column in *Shape* magazine, presented "Sustaining Our Healing Spirit", Thursday, April 15, 1993, at the First House of Delegates.



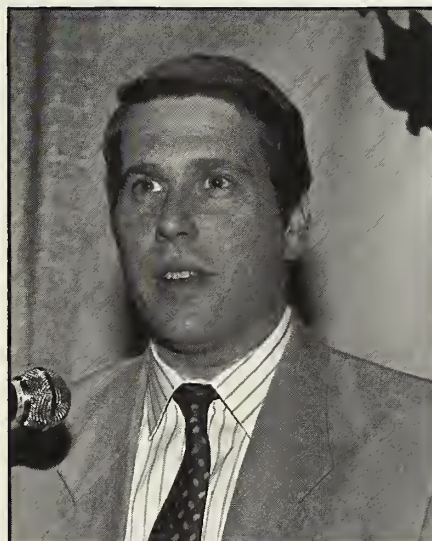
**Paul Bachner, M.D.**, Chairman of the Department of Pathology and Laboratory Medicine at United Hospital Medical Center in Port Chester, New York, spoke on "CLIA-88: The Law, The Regulations, and Impact on Physicians", Friday, April 16, 1993 at the First Feature Session.



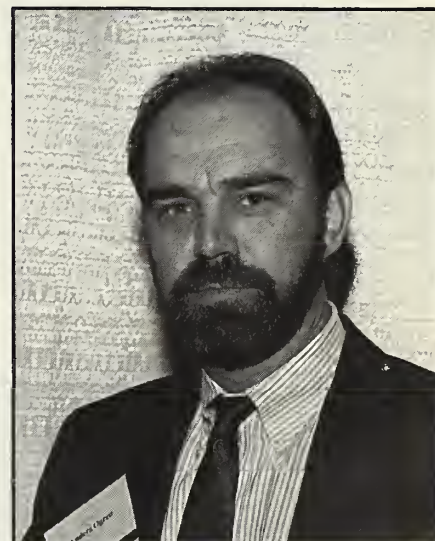
**Ed Goaes**, President and CEO of the Tarrance Group, one of the most respected and successful Republican survey research and strategy teams in American politics, and a pollster for *U.S. News & World Report*, spoke on Friday, April 16, 1993 at the Shuffield Luncheon.



**U.S. Congressman Jay Dickey**, spoke at the Second Feature Session on Friday, April 16, 1993. He updated the physicians on federal legislature activities in regard to health care reform and reviewed common concerns that have been shared with him by 4th Congressional District physicians.



**Edmund F. Haislmaier**, Senior Policy Analyst for Health Care Issues at the Heritage Foundation, a Washington-based public policy research institute, presented a speech on "Reform of the U.S. Health Care System", Friday, April 16, 1993 at the Second Feature Session.



**Paul Anders Ogren**, presented "Universal Health Care - The Minnesota Plan", Saturday, April 17, 1993 at the Third Feature Session. A former state representative, he capped a 12-year legislative career with the passage of *Health Right*, Minnesota's landmark health care reform & cost containment act.



# House of Delegates

## First Session - April 15, 1993

Speaker of the House John Crenshaw called the meeting to order on Thursday, April 16, 1993, at the 117th annual meeting of the Arkansas Medical Society. Dr. Larry Lawson asked for a moment of silence in memory of the physicians and auxiliaries that had passed away in the past year and gave the invocation. The Arkansas National Guard presented the colors.

Dr. John Crenshaw introduced the following auxiliary members and guests: Mrs. Mildred Taylor, President-elect, Southern Medical Association Auxiliary; Mrs. Barbara Tippins, Field Director, American Medical Association Auxiliary; Mrs. Sandy Harrison, President, Arkansas Medical Society Auxiliary; and Mrs. Arleta Power, President-elect, Arkansas Medical Society Auxiliary.

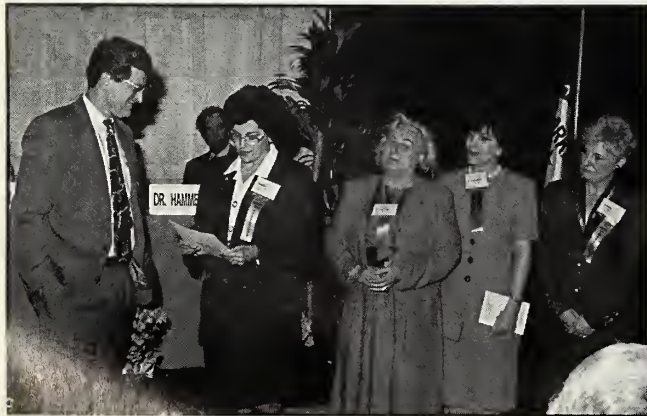
Mrs. Sandy Harrison presented Dr. I. Dodd Wilson, Dean of the University of Arkansas College of Medicine, with two checks from the American Medical Association Education and Research Foundation. The first check in the amount of \$3,011.00 was for pursuit of excellence in the medical school's program and the other check in the amount of \$9,512.87 is restricted to the school's program of financial assistance for medical students.

Dr. Crenshaw announced there were 81 voting members in attendance.

Upon motion, the House approved the minutes of the 116th annual session as published in the June 1992 issue of *The Journal of the Arkansas Medical Society*.

Dr. Charles Logan made presentations to Dr. F. E. Joyce and Dr. Merrill Osborne for their years of service on the Council. (Dr. F. E. Joyce was not in attendance.) Dr. Larry Lawson also presented awards to Dr. A. E. Andrews and Dr. Asa Crow for their service as delegates to the American Medical Association.

*Sandy Harrison presents Dr. I. Dodd Wilson two checks from AMA-ERF.*



*Dr. Carl Hammerschlag with Dr. W. Payton Kolb and Dr. Brenda Powell.*

Dr. Crenshaw announced the vacancy in the old Fourth Congressional District on the State Medical Board and reminded the members from those counties in the district to meet immediately following the adjournment of the House to vote for three nominees for the term of office that will expire in the year 2000. The vacancy is due to the death of Dr. Curtis Ripley. Counties in the old Fourth Congressional District are Ashley, Bradley, Calhoun, Clark, Columbia, Hempstead, Howard, Little River, Lafayette, Miller, Montgomery, Nevada, Ouachita, Pike, Polk, Sevier, and Union.

Dr. Crenshaw announced the 1993-1994 Nominating Committee members. Committee members representing the odd numbered districts are: District #1: Dr. Merrill Osborne, Blytheville; District #3: Dr. Francis Patton, Helena; District #5: Dr. Robert Nunnally, Camden; District #7: Dr. Thomas H. Hollis, Hot Springs, reappointed; and District #9: Dr. Carlton Chambers, Harrison. Committee members representing the even numbered districts are: District #2: Dr. Michael N. Moody, Salem; District #4: Dr. Lee A. Forestiere, Pine Bluff; District #6: Dr. Herbert B. Wren, Texarkana; District #8: Dr. Harold Purdy, Little Rock; and District #10: Dr. William W. Galloway, Russellville.

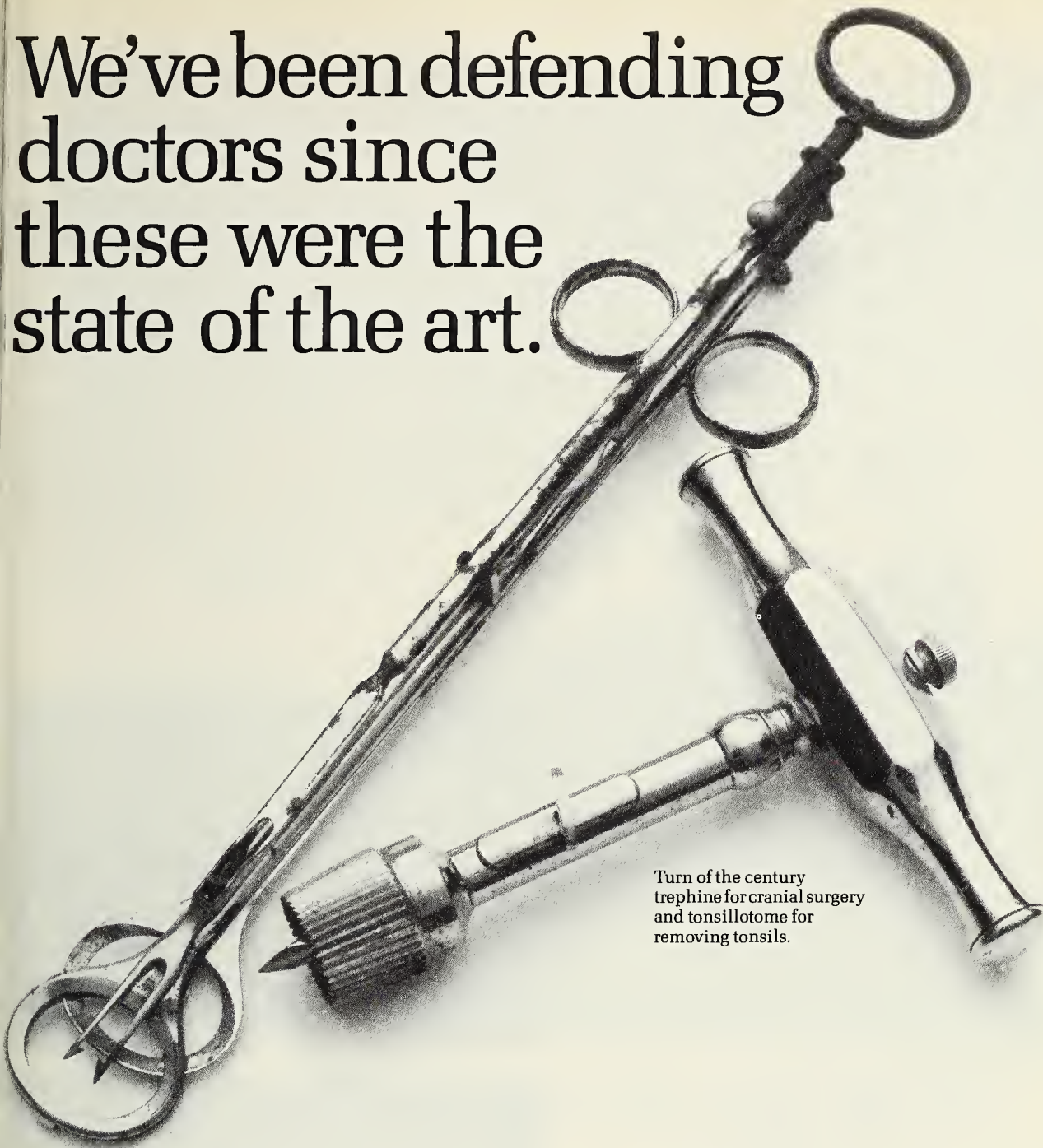
Dr. Crenshaw reminded the House of the reference committee meetings to be held Friday, April 16th.

Dr. Crenshaw turned the podium over to Dr. Brenda Powell, Vice Speaker, who introduced Dr. Carl Hammerschlag, the keynote speaker. Dr. Hammerschlag, an internationally recognized psychiatrist, lecturer, author, and healer, spoke on "Sustaining Our Healing Spirit".

After announcements the meeting adjourned until Saturday, April 17th.



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# House of Delegates

## Final Session - April 17, 1993

Speaker of the House John Crenshaw called the meeting to order on Saturday, April 17, 1993, and asked the Nominating Committee Chairman, Dr. Mike Moody, to present the slate of officers:

### President-elect:

James M. Kolb, Jr., M.D., Russellville

### Vice President:

Vacant

### Treasurer:

Lloyd G. Langston, M.D., Pine Bluff

### Secretary:

Charles H. Rodgers, M.D., Little Rock

### Speaker of the House:

John Crenshaw, M.D., Pine Bluff

### Vice Speaker of the House:

Brenda Powell, M.D., Hot Springs

### Councilors:

District 1: Don B. Vollman, Jr., M.D., Jonesboro

District 2: Lloyd G. Bess, M.D., Batesville

District 3: Hoy B. Speer, Jr., M.D., Stuttgart

District 4: Anna T. Ridling, M.D., Pine Bluff

District 5: Wayne G. Elliott, M.D., Camden

District 6: John A. Gillean, M.D., Texarkana

District 7: Thomas H. Hollis, M.D., Hot Springs

District 8: Paul J. Cornell, M.D., Little Rock

William N. Jones, M.D., Little Rock

Charles W. Logan, M.D., Little Rock

Joseph Beck, M.D., Little Rock

J. Mayne Parker, M.D., Little Rock

(new councilor position)

District 9: David L. Rogers, M.D., Fayetteville

District 10: Paul I. Wills, M.D., Fort Smith

### Delegates to the AMA:

James R. Weber, M.D., Jacksonville

(1/1/94 - 12/31/95)

William N. Jones, M.D., Little Rock

(1/1/93 - 12/31/94 to fill Dr. Asa Crow's  
unexpired term)

### Alternate Delegate to the AMA:

J. Larry Lawson, M.D., Paragould (to fill Dr. Jones'  
unexpired term ending 12/31/93 and serve term  
beginning 1/1/94 - 12/31/95)

Dr. James Kolb was elected president-elect by acclamation as were other nominees. The position of vice president was left open to be voted on by the Council. Dr. Kolb addressed the House.

The next order of business was the reports from the reference committees. The adoption of these reports were approved.

The report of the Council was given by Dr. Charles Logan, Chairman, and approved by the House to be filed for information.

Dr. James Armstrong, Chairman of the Board of Directors of the Arkansas Foundation for Medical Care, reported on changes of the PRO.

Dr. Crenshaw announced the following nominees for the Fourth Congressional District on the State Medical Board: Dr. C. Eldon Tommey, El Dorado; Dr. Robert Nunnally, Camden; and Dr. Wayne Elliott, El Dorado.

Dr. Crenshaw announced the following officers of the Nominating Committee: Dr. Michael Moody, Salem, Chairman and Dr. William Galloway, Russellville, Secretary.

Dr. Larry Lawson gave a farewell address to the delegates and members. Mr. Ken LaMastus presented Dr. Lawson with a gift from the AMS staff.

Mr. Lynn Zeno, Director of the Governmental Affairs Committee, gave a legislative report on the 1993 session.

There being no further business the meeting adjourned.



Above top: Members of the Executive Committee.  
Above: House of Delegates.





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James M. Kolb, Jr., Russellville, President-elect  
Vice President - vacant  
J. Larry Lawson, Paragould, Immediate Past President  
Charles Logan, Little Rock, Chairman of the Council  
Charles Rodgers, Little Rock, Secretary  
Lloyd Langston, Pine Bluff, Treasurer  
John Crenshaw, Pine Bluff, Speaker of the House  
Brenda Powell, Hot Springs, Vice Speaker of the House

### **EXECUTIVE COMMITTEE**

Charles Logan, Little Rock, Chairman of the Council  
Glen F. Baker, Little Rock, President  
James M. Kolb, Jr., Russellville, President-elect  
Charles Rodgers, Little Rock, Secretary  
Lloyd Langston, Pine Bluff, Treasurer  
J. Larry Lawson, Paragould, Immediate Past President

### **COUNCILORS AND COUNCILOR DISTRICTS**

#### **FIRST DISTRICT**

Dwight Williams, Paragould (1994); Don B. Vollman, Jonesboro (1995); Clay, Craighead, Crittenden, Greene, Lawrence, Mississippi, Poinsett, Randolph

#### **SECOND DISTRICT**

Michael Moody, Salem (1994); Lloyd Bess, Batesville (1995); Cleburne, Conway, Faulkner, Fulton, Independence, Izard, Jackson, Sharp, Stone, White

#### **THIRD DISTRICT**

Samuel McGuire, Forrest City (1994); Hoy Speer, Stuttgart (1995); Arkansas, Cross, Lee, Lonoke, Monroe, Phillips, Prairie, St. Francis, Woodruff

#### **FOURTH DISTRICT**

Paul Wallick, Monticello (1994); Anna T. Ridling, Pine Bluff (1995); Ashley, Chicot, Desha, Drew, Jefferson, Lincoln

#### **FIFTH DISTRICT**

Robert Nunnally, Camden (1994); Wayne Elliott, El Dorado (1995); Bradley, Calhoun, Cleveland, Columbia, Dallas, Ouachita, Union

#### **SIXTH DISTRICT**

James Armstrong, Ashdown (1994); John A. Gillean (1995); Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Pike, Polk, Sevier

#### **SEVENTH DISTRICT**

Ronald Bracken, Hot Springs (1994); Thomas Hollis, Hot Springs (1995); Clark Garland, Grant, Hot Spring, Montgomery, Saline

#### **EIGHTH DISTRICT**

David Barclay, Little Rock (1994); R. Jerry Mann, Little Rock (1994); Harold Purdy, Little Rock (1994); Joseph Beck, Little Rock (1995); Paul Cornell, Little Rock (1995); William Jones, Little Rock (1995); Charles Logan, Little Rock (1995); J. Mayne Parker, Little Rock (1995); Pulaski

#### **NINTH DISTRICT**

Robert Langston, Harrison (1994); Janet Titus, Winslow (1994); David Rogers, Fayetteville (1995); Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, Van Buren, Washington

#### **TENTH DISTRICT**

Morton C. Wilson, Fort Smith (1994); Gerald Stolz, Russellville (1994); Paul Wills, Fort Smith (1995); Crawford, Franklin, Johnson, Logan, Perry, Pope, Scott, Sebastian, Yell

## Reference Committee #1



Simmie Armstrong, M.D., Pine Bluff, Chairman  
David Bourne, M.D., Little Rock  
William White, M.D., Searcy  
Ms. Debbie Hays, Medical Student Observer

This Reference Committee recommends that the following reports printed in the March issue of *The Journal of the Arkansas Medical Society* be filed for information:

AMS Benefits, Inc., Mr. David Wroten, Vice President  
Budget Committee, Dr. Wayne Elliott, Chairman  
Pension Plan Trustees, Dr. James Pappas, Chairman  
Report of the Executive Vice President,  
Mr. Ken LaMastus  
Report of the Council, Dr. Charles Logan, Chairman

HOUSE ACTION: FILED FOR INFORMATION

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### Report of the Ad Hoc Committee for a UAMS Scholarship Program, Dr. Bob Gosser, Chairman

This Reference Committee heard several comments concerning the need, especially in Arkansas, to encourage students to go into primary care. Therefore, this Reference Committee recommends that the Ad hoc Committee for a UAMS Scholarship Program be encouraged to consider placing an emphasis on those students planning or considering primary care specialties and that this report be filed for information.

HOUSE ACTION: FILED FOR INFORMATION

### Report of the Medical Education Foundation for Arkansas (MEFFA), Dr. Martin Eisele, President

Of particular note during the testimony were suggestions and comments regarding increasing the contribution to MEFFA by an additional \$5.00 to \$10.00. Obviously this would entail either an increase in our AMS dues or a diversion from other AMS programs. While the Reference Committee was supportive of the need to increase MEFFA funds, we did not feel that we had sufficient information regarding the financial impact of such a recommendation. Therefore, this Reference Committee recommends that the Report on the Medical Education Foundation for Arkansas be filed for information.

HOUSE ACTION: FILED FOR INFORMATION

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### Report of the Physicians' Health Committee, Dr. Joe Martindale, Chairman

During the testimony it was obvious that the Physicians' Health Committee is having an important impact on our colleagues who suffer from chemical dependency. Considerable testimony emphasized the need to seek additional funding sources which will enable the Physicians' Health Committee to operate at its full potential. Mr. Speaker, this reference committee recommends that the members of the Physicians' Health Committee be commended for their untiring efforts on behalf of the Arkansas Medical Society and that the report of the Physicians' Health Committee be filed for information.

HOUSE ACTION: FILED FOR INFORMATION







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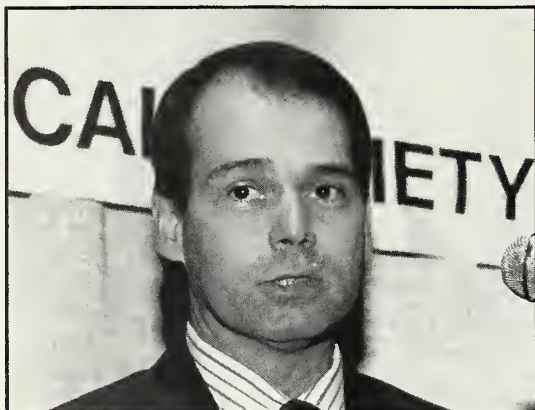


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## Reference Committee #2



Bill Dedman, M.D., Camden, Chairman  
Joseph Beck, M.D., Little Rock  
Richard Calleton, M.D., Mena  
Gail McCracken, M.D., Little Rock  
Joe Stallings, M.D., Jonesboro  
Ms. Amanda Ferrell, Medical Student Observer

This Reference Committee recommends that the following reports printed in the March issue of *The Journal of the Arkansas Medical Society* be filed for information:

AMS Medical Student Section, Ms. Katherine E. Henry, President  
Arkansas Health Care Access Foundation, Dr. Gil Buchanan, Chairman  
Arkansas State Medical Board, Ms. Peggy Pryor Cryer, Executive Secretary  
Committee on Position Papers, Dr. James M. Kolb, Jr., Chairman  
Nominating Committee, Dr. Michael Moody, Chairman  
Physician Advisory Committee, Dr. Howell Hill, Chairman  
Pulaski County Medical Society, Mr. Fred Reddoch, Executive Director  
Task Force on AIDS, Dr. Joseph M. Beck II, Chairman

HOUSE ACTION: FILED FOR INFORMATION

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### Report of Annual Session Committee, Dr. Glen F. Baker, Chairman

This Reference Committee recommends that Dr. Glen Baker be recognized and commended for his

excellent leadership while serving as chairman of the Annual Session Committee and that this report be filed for information.

HOUSE ACTION: FILED FOR INFORMATION

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### Report of Governmental Affairs Council, Dr. Charles H. Rodgers, Chairman

This Reference Committee recommends that the following individuals be commended for their diligent and persistent efforts in representing our interests and the interests of our patients: Lynn Zeno, Laura Harrison, David Wroten, all the physicians that contributed to Med-Pac, Dr. Michael Moody, Dr. Bill Jones, Dr. Charles Rodgers, and Dr. Payton Kolb who compose our physician lobbying team. And we further recommend that this report be filed for information.

HOUSE ACTION: FILED FOR INFORMATION

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### Report of Ouachita County Medical Society, Dr. Robert H. Nunnally, President

This Reference Committee recommends that Dr. Robert Nunnally be commended for his efforts in rejuvenating the Ouachita County Medical Society and that this report be filed for information.

HOUSE ACTION: FILED FOR INFORMATION

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### Report of the Arkansas Department of Health to AMS, Dr. M. Joycelyn Elders, Director

This Reference Committee recommends that we acknowledge and congratulate Dr. Joycelyn Elders for her nomination as the U.S. Surgeon General and that this report be filed for information.

HOUSE ACTION: FILED FOR INFORMATION





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Session summaries are as follows:

## **"CLIA-88: The Law, The Regulations, and Impact on Physicians"**

Paul Bachman, M.D., Chairman of the Department of Pathology and Laboratory Medicine at United Hospital Medical Center in Port Chester, New York, discusses the major provisions of CLIA and how they will affect your practice.

## **"Reform of the U. S. Health Care System"**

Edmund F. Haislmaier, Senior Policy Analyst for Health Care Issues at the Heritage Foundation, a Washington-based public policy research institute, is the principal architect of the Foundation's "consumer choice" proposal for national health care reform.

## **"Shuffield Luncheon Speaker - Edward A. Goaes"**

Edward A. Goaes is President and CEO of the Tarrance Group, one of the most respected and successful Republican survey research and strategy teams in American politics.

## **"Universal Health Care - The Minnesota Plan"**

Paul Anders Ogren, a former Minnesota state representative, capped a 12-year legislative career with the passage of Health Right, Minnesota's landmark health care reform and containment act.



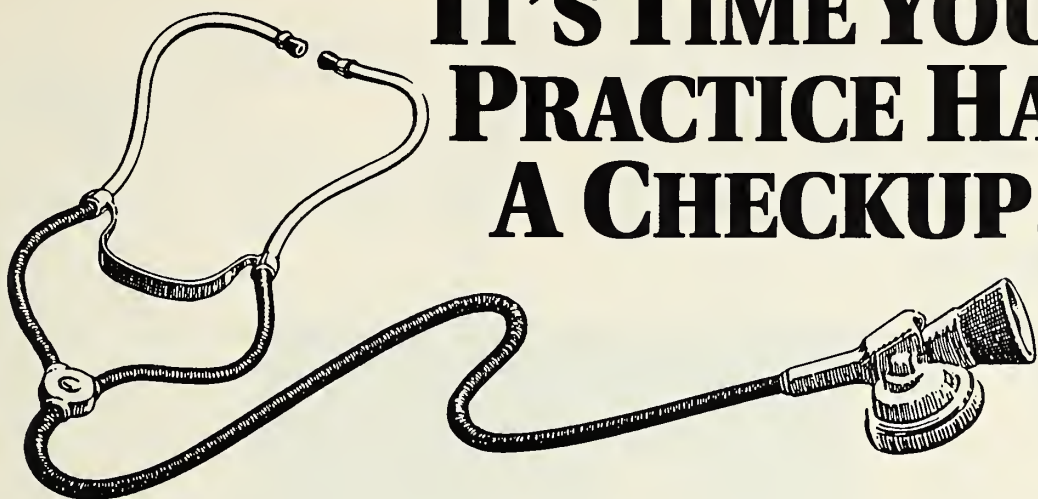
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"Reform of the U. S. Health Care System"	\$10.00	_____
"Shuffield Luncheon Speaker - Edward A. Goaes"	\$10.00	_____
"Universal Health Care - The Minnesota Plan"	\$10.00	_____
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| Would your professional liability insurance premiums be paid?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your property and casualty insurance premiums be paid?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your practice's taxes be paid?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your practice's utility bills be paid?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would professional or trade dues be paid?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
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# Report of the Council

April 15-17, 1993



The Council met April 15-17 and the following business was received and transacted:

1. Approved the minutes of the February 21, 1993 Council meeting.
2. Received an update from Dr. James Adamson of Blue Cross Blue Shield on National Medicare Statistics. Upon motion the Council approved the formulation of a subcommittee to put this information in a report to publicize to Arkansas Medical Society members.
3. Approved the revisions to the Arkansas Medical Society Auxiliary's Bylaws.
4. Received an update from Dr. William Jones on current issues related to AIDS.
5. Received an update from Dr. Joseph Beck on the Arkansas State Medical Board's policy on HIV.
6. Received an update from Dr. Larry Lawson Summit Meeting held in Washington, DC on March 23-25.
7. Received an update from Dr. Michael Moody on National Rural Health Conference held in Little Rock on March 11, 1993.
8. Received a report from Mr. David Wroten on the Medicaid Managed Care Proposal and our response to HCFA.
9. The Council recognized Dr. Merrill Osborne for his 16 years of dedication to the Council. Dr. Don Vollman was introduced as the new Councilor for the First District for the coming year.
10. A brief summary of the Legislative Session was given by Mr. Lynn Zeno. The Council approved a motion that the summary of the Legislative Session would be presented to the House of Delegates by Mr. Lynn Zeno and would also be printed in *The Journal of the Arkansas Medical Society*.
11. Approved a motion that Mr. Mike Mitchell and Mr. Lynn Zeno be recognized as the two most effective and respected lobbyists at the State

Capitol and that the Council would go on record commending these two for their good work.

12. Recognized the members of the Governmental Affairs Committee and received an update of the activities of the GAC.
13. Received the Membership and Budget Reports for the period ending February 28, 1992 and the 1992 AMS Audit.
14. Approved a motion that would make the terms of service of members who are serving on both the Physicians' Advisory Committee and the Medical Services Review Committee as being the same.
15. Approved the following appointments:

#### **UAMS Scholarship Committee:**

Cal Sanders, Camden  
Danny Proffitt, Fayetteville  
John Williams, Blytheville  
Bob Gosser, North Little Rock, Chairman

#### **Medical Services Review Committee:**

Family Practice, Ralph Joseph, Little Rock  
Internal Medicine, H. Kevin Beavers, Russellville  
General Surgery, William Gibbs, Searcy  
Obstetrics/Gynecology, Travis Crews, Little Rock  
Pediatrics, Anthony D. Johnson, Little Rock  
Pathology, William Atkinson, Little Rock  
Orthopaedic Surgery, Jay Lipke, Little Rock

#### **Medical Services Review Committee's Subcommittee of Subspecialties:**

Emergency Medicine, Marvin Leibovich, Little Rock  
Cardiovascular, William Fiser, Little Rock  
Gastroenterology, John T. Baber, Little Rock  
Nephrology, Ronald D. Hughes, Little Rock  
Oral Surgery, Robert Anderson, Little Rock  
Pediatric Allergy, Fred J. Kittler, Little Rock  
Plastic Surgery, Luther Walley, Little Rock  
Pulmonary Diseases, Gail McCracken, Little Rock  
Thoracic Surgery, Ben Lincoln, Little Rock

#### **Arkansas Medical Society Pension Plan Board of Trustees:**

William Nowlin of Fayetteville

#### **Medical Education Foundation for Arkansas (MEFFA):**

James Kyser and William Bishop of Little Rock



*The Council of the Arkansas Medical Society.*

**Committee on Position Papers:**

Paul Wills, Fort Smith  
Paul Wallick, Monticello  
P. Martin Fiser, Little Rock  
Roger Cagle, Paragould  
Peter Marvin, North Little Rock  
David Busby, Alma, serving as chairman

**Budget Committee:**

Robert Langston, Harrison

**Young Physicians Committee:**

District 1: Steve Schoettle, West Memphis  
District 2: Griffin Arnold, Salem  
District 8: Elicia Sinor, Little Rock  
Anna Ridling, Pine Bluff, chairman

**Physician Advisory Committee:**

Otolaryngology: A. Reed Thompson, Little Rock

16. Approved the following requests for dues exemptions:

**Life Membership:**

David L. Gibbons, Franklin County; Byron E. Holmes, Lonoke County; Walter C. Barnes, Miller; L. J. P. Bell, Phillips County; David M. Yocum, Union County; John A. Hall, Van Buren; Joe B. Hall, Washington; James O. Pennington, Yell County.

**Emeritus Membership:**

Joe D. Bennett, Boone County; Major E. Smith, Chicot County; Herman D. Alston, James W. Basinger, Henry W. Keisker, and Vestal B. Smith, Craighead-Poinsett Counties; Vance J. Crain, Cross County; John H. Delamore, Dallas County; Robert Benafield, Faulkner County; Clawrence R. Lovell, Garland County; A. E. Andrews, Miller County; Johnson Baker, Amail Chudy, William T. Dungan, W. Sexton Lewis, E. L. Milner, Thomas J. Smith, Pulaski County; Neil

E. Crow, Sr., James A. Gill, Ken E. Lilly, Thomas H. Raymond, and Leon P. Woods, Sebastian County.

**Affiliate Membership:**

Helga E. Chock, Baxter; John W. Jacks and Patrick K. Keane, Benton County; Robert E. Burns, Drew County; William R. Mashburn, Garland County; Norman W. Peacock, Jr., Little River County; William J. Roberts, Logan County; R. Lee Austin, Donald G. Browning, Guy R. Farris, Jr., George M. Goza, Jr., J. Harry Hayes, Jr., Ben O. Price, E. Clinton Texter, Jr., Pulaski County; Joseph H. McAlister and Vincent B. Runnells, Washington County; and Henry C. Farrar, White County.

17. Dr. Glen Baker discussed the Arkansas Medical Society Building and the limited partnership's previous investment.
18. Upon motion approved appointment of a committee to readdress the issue of the limited partnership and see if there is a mechanism which would recognize those members of the limited partnership that lost money in that investment.
19. Approved a motion to develop a committee which would include the Executive Committee to monitor issues on National Health Care Reform and make recommendations to the Arkansas Medical Society concerning these issues.
20. Received an update from Dr. James Armstrong on the activities of the PRO.
21. Recognized Dr. F. E. Joyce for his 12 years of dedication to the Council.
22. Mr. Ken LaMastus announced that the Arkansas Medical Society is working with the Arkansas Department of Health in planning a reception to be held in May in honor of Dr. Joycelyn Elders, the United States Surgeon General designate.
23. Approved a letter to be signed by the president of the Arkansas Medical Society commending Dr. Joycelyn Elders upon her appointment as the United States Surgeon General designate and her sincere dedication to health care in Arkansas.

This concludes the report of the Council.



# Arkansas Medical Society

## Final Legislative Report

### 79th General Assembly

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#### MESSAGE TO AMS MEMBERS

The 79th Session of the Arkansas General Assembly ended on April 8, 1993, and again the Arkansas Medical Society enjoyed a successful session.

**OUR INCREASED POLITICAL EFFECTIVENESS THROUGH MED-PAC CONTRIBUTIONS AND GRASSROOTS COMMUNICATION WITH INDIVIDUAL LEGISLATORS IS EVIDENCED BY OUR CONTINUED SUCCESS.**

There were 2,000 bills and resolutions introduced in the 88-day session. One hundred and thirty-nine of those were health-related, and a record 63 of those were enacted into law (copies of those Acts can be obtained by contacting the AMS office).

Many of the bills that were detrimental to the medical profession and the patients we serve did not pass. However, they were referred to Joint Interim committees for further study. This means that we will be busy and will continue to need your legislative communication in the next two years prior to the 1995 legislative session.

We also anticipate another special session to deal with Medicaid issues and possibly promulgate state regulations to satisfy any mandates that result from federal health care reforms.

One thing is for certain . . . health care will continue to be in the forefront of everyone's political agenda and we must continue our active political involvement.

Special thanks to all AMS members and auxiliaries who contacted their legislators on important medical matters, and especially to those physicians who voluntarily served at the Capitol as "Doctor of the Day."

Charles "Shot" Rodgers, M.D., Chairman  
AMS Governmental Affairs Council

Z. Lynn Zeno  
Director of Governmental Affairs

Laura Harrison  
Special Projects Coordinator

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Department of Governmental Affairs



# 1993 LEGISLATIVE SCOREBOARD

The following are the medical-related bills acted upon during the 79th General Assembly. The first bills listed are those of special interest representing our significant victories and losses. Next is a synopsis of other bills considered, along with final action and the AMS position on those bills.

## SIGNIFICANT VICTORIES

It should be noted that we consider our most significant victory, the fact that the "Provider Tax on PHYSICIAN GROSS REVENUES," which we successfully defeated in the December special session was not re-introduced in the regular session.

SB 247 (Walters) Amended the medical malpractice statute of limitations by expanding the length of time for filing action. **DEFEATED IN THE HOUSE/AMS OPPOSED.**

SB 490 (Walters) Established primary health care clinics in each county to be staffed by UAMS/AHEC personnel. **REFERRED TO JOINT INTERIM COMMITTEE/AMS OPPOSED.**

SB 572 (Walters) Prohibits physicians from denying treatment to individuals solely because of age (can't deny treatment to Medicare patients.) **REFERRED TO JOINT INTERIM COMMITTEE. COMPROMISE REACHED WITH SENIOR CITIZENS . . . SEE SB 604/AMS OPPOSED.**

SB 604 (Miles) Requires notice to be placed in physician offices as to Medicare assignment policies. **REFERRED TO JOINT INTERIM COMMITTEE. COMPROMISE WITH SENIOR CITIZENS TO VOLUNTARILY PLACE SIGN IN OFFICES/AMS OPPOSED.**

SB 746 (Moore, Walters) Establishes regulations for "Advance Practice Nurses," allowing independent practice and prescribing authority. **REFERRED TO JOINT INTERIM COMMITTEE/AMS OPPOSED.**

HB 1615 (M. Wilson, et al) Comprehensive Workers' Compensation Re-structuring Act. Protects workers' compensation fee schedule under Rule 30, however, tightens requirements for compensable injury. **ACT 796/AMS SUPPORTED.**

HB 1707 (Wingfield) Created an Oriental Medical Board. **REFERRED TO JOINT INTERIM COMMITTEE/AMS OPPOSED.**

HB 1957 (Collier) "Impaired Physician and Dentist Treatment Act." Provides civil immunity for reporting of impaired physicians. **ACT 1220/AMS SUPPORTED.**

HB 2024 (Collier, Fairchild) Health Promotion and Consumer Protection Act. Defines "CDC Guidelines" and "OSHA Blood-borne Pathogen Standards." Prohibits discrimination against or civil or criminal liability for any worker who reports employer for failure to comply with standards (whistle blower bill). **REFERRED TO JOINT INTERIM COMMITTEE/AMS OPPOSED.**

HB 2118 (Hawkins) Would force work and public places to have a "designated" smoking area and prohibit cities and counties from passing restrictive smoking ordinances. **DEFEATED IN THE HOUSE/AMS OPPOSED.**

## SIGNIFICANT LOSSES

SB 249 (Bearden) Requires insurance payments for services of Certified Registered Nurse Anesthetists to be same as persons licensed under the Medical Practices Act. (This bill was aimed primarily at out-of-state insurance carriers. It is currently standard practice for most carriers including BCBS.) **ACT 577/AMS OPPOSED.**

SB 422 (Wilson) Allowed Arkansas income tax credits to physicians practicing in certain rural areas of the state. **WITHDRAWN AT GOVERNOR'S REQUEST DUE TO FISCAL IMPACT/AMS SUPPORTED.**

HB 1292 (Stewart) "Good Samaritan Act." Provided civil immunity to physicians rendering free and voluntary medical treatment. **PASSED BY THE HOUSE AND SENATE, VETOED BY THE GOVERNOR/AMS SUPPORTED.**

HB 1389 (Flanagan) Tobacco Tax for Children First Trust Fund. Levied 20% tax on wholesalers gross receipts and 22% tax on tobacco products. **DEFEATED IN HOUSE COMMITTEE/AMS SUPPORTED.**



# OTHER BILLS OF INTEREST

## SENATE BILLS

- SB 17 (Moore) Appropriates \$650,000 for South Arkansas Radiation Therapy Institute. **ACT 24/AMS SUPPORTED.**
- SB 34 (Miles) Increases penalties for failure to wear seat belts. **PASSED THE SENATE. DEFEATED IN HOUSE COMMITTEE/AMS SUPPORTED.**
- SB 35 (Miles) Requires seat belt usage for all motor vehicle occupants. **DEFEATED IN THE SENATE/AMS SUPPORTED.**
- SB 92 (Dowd) Defines and creates Board of Disease Intervention Specialists (HIV/AIDS counselors). **ACT 107/AMS NEUTRAL.**
- SB 95 (Walters) Provides a presumption that drivers wish to be anatomical donors. **ACT 409/AMS SUPPORTED.**
- SB 111 (Jt. Budget) Appropriates \$100,000 for cancer research. **ACT 34/AMS SUPPORTED.**
- SB 155 (Ross) Restores jury duty exemption for health care professionals. **DIED ON THE CALENDAR/AMS SUPPORTED.**
- SB 167 (Hoofman) Permits conditional employment of non-state licensed credentialed psychologists by state agencies. **WITHDRAWN FROM CONSIDERATION/AMS NEUTRAL.**
- SB 233 (Dowd) Rights of the Terminally Ill. Clarifies definitions regarding "life sustaining treatment" and "permanently unconscious." **DIED ON THE CALENDAR/AMS NEUTRAL.**
- SB 252 (Moore) Clarifies that the practice of optometry does not include the use of prescription oral drugs. **ACT 176/AMS SUPPORTED.**
- SB 269 (Beebe, et al) Appropriates \$650,000 to construct and equip Central Arkansas Radiation Therapy Institute. **ACT 147/AMS SUPPORTED.**
- SB 272 (Harriman, Malone) Encourages use of Alternative Dispute Resolution Processes in all branches of government and the courts. **WITHDRAWN FROM CONSIDERATION/AMS SUPPORTED.**
- SB 282 (Luelf) Appropriates \$650,000 to construct and equip Radiation Therapy Institute in Mountain Home. **ACT 148/AMS SUPPORTED.**
- SB304 (Holiman, et al) Requires that monies received under Medicaid Drug Rebate Program be dedicated to pay Medicaid pharmacy claims. **ACT 289/AMS NEUTRAL.**
- SB 307 (Bell) Establishes policy that Medicaid is payor of last resort, if other coverage is available. **ACT 249/AMS NEUTRAL.**
- SB 314 (Bookout, Gwatney) Increases penalty for late registration with the State Medical Board. **ACT 275/AMS NEUTRAL.**
- SB315 (Bookout, Gwatney) Amends Medical Board regulations regarding physicians licensed by credentials. **ACT 276/AMS NEUTRAL.**
- SB 316 (Bookout, Gwatney) Increases maximum fines the Medical Board is allowed to levy for violation of Medical Practices Act. **ACT 290/AMS NEUTRAL.**
- SB 317 (Bookout, Gwatney) Allows for shared investigators by Medical Board, Dental Board, Nursing Board, Veterinary Board and Podiatry Board. **ACT 1146/AMS SUPPORTED.**
- SB 318 (Bookout, Gwatney) Eliminates discount for medical license re-examination fee. **DIED ON THE CALENDAR/AMS NEUTRAL.**
- SB 319 (Bookout, Gwatney) Increases fee for licensing of physician assistants. **ACT 277/AMS NEUTRAL.**
- SB 366 (Bearden, et al) Abolishes Optometric Therapeutic Committee. (Same as HB 1460) **ACT 323/AMS NEUTRAL.**
- SB 423 (Yates) Decreases from 10 to 3 days the filing period for a death certificate; decreases from 48 to 24 hours the period in which a medical certificate must be completed. (Same as HB 1017) **WITHDRAWN FROM FURTHER CONSIDERATION/AMS OPPOSED.**

SB 424 (Hardin) Allows family member or other responsible person to identify medical bills in a civil case. Removes the necessity of expert witnesses for such documentation. **ACT 424/AMS SUPPORTED.**

SB 446 (Jewell) Merges the State Hospital into UAMS. **REFERRED TO JOINT INTERIM COMMITTEE/AMS NEUTRAL.**

SB 450 (Yates) Authorizes physicians to report patients who pose a risk to themselves or others if allowed to operate a motor vehicle. **WITHDRAWN FROM FURTHER CONSIDERATION/AMS OPPOSED.**

SB 480 (Todd) Provides that hospitalization beyond 72 hours for mental disorders or substance abuse shall not be eligible for Medicaid reimbursement without determination of need by independent examination. **DIED ON THE CALENDAR/AMS NEUTRAL.**

SB 482 (Bell) Prohibits creating trusts that divest income or beneficial interest for the purpose of seeking Medicaid eligibility. **ACT 1228/AMS NEUTRAL.**

SB 489 (Walters) Allows restricted drivers license for persons with corrected vision less than 20/50. Same as HB 1376. **PASSED THE SENATE. DEFEATED IN THE HOUSE/AMS SUPPORTED.**

SB 500 (Chaffin) "Arkansans with Disability Act." State regulations to run concurrent with Americans with Disabilities Act (ADA.) **WITHDRAWN FROM FURTHER CONSIDERATION/AMS SUPPORTED.**

SB 502 (Holiman, et al) Creates "Arkansas Health Resources Commission." Authorizes employment of a director and requires Commission to catalog all health related agencies and associations. Allows analysis and studies of health care system. **ACT 591/AMS NEUTRAL.**

SB 512 (Malone) Requires license for all "Life Care Providers" (continuing care facilities.) **ACT 787/AMS NEUTRAL.**

SB 527 (Moore) Provides for extra \$5 assessment on moving traffic violation fines with proceeds dedicated toward EMS and Trauma System improvements. "Five for Life." **DEFEATED IN THE SENATE/AMS SUPPORTED.**

SB 543 (Snyder) Authorizes certain nursing personnel to request and receive laboratory test at the Arkansas Health Department under Department protocols and physician supervision. Adheres to federal CLIA guidelines. **ACT 485/AMS SUPPORTED.**

SB 550 (Hopkins, et al) Comprehensive Workers' Compensation Bill. **WITHDRAWN FROM CONSIDERATION/AMS NEUTRAL.**

SB 576 (Moore) Authorizes development and implementation of a statewide trauma system. **ACT 559/AMS SUPPORTED.**

SB 579 (Hardin) Requires reporting of head injuries to the Central Head Injury Registry. **WITHDRAWN FROM FURTHER CONSIDERATION/AMS SUPPORTED.**

SB 583 (Judiciary Committee) Comprehensive Workers' Compensation Bill. **DIED ON THE CALENDAR/AMS NEUTRAL.**

SB 625 (Todd) Creates Task Force on Alzheimer's Disease. **ACT 1194/AMS SUPPORTED.**

SB 639 (Harriman) Renames the State Spinal Cord Commission to the Arkansas Spinal Cord Commission. **ACT 1154/AMS NEUTRAL.**

SB 648 (Walters) "Comprehensive Health Care Information Act" - regarding medical record confidentiality, release, and availability, etc. **REFERRED TO JOINT INTERIM COMMITTEE/AMS NEUTRAL.**

SB 679 (Bearden) Authorizes Board of Optometry to define parameters for opticians care/treatment of the eye (contained AMS amendments). **ACT 1271/AMS NEUTRAL.**

SB 697 (Gwatney) Authorizes insurers to issue Children's Basic Primary and Preventive Benefit policies. **ACT 1158/AMS SUPPORTED.**

SB 700 (Bradford, et al) Establishes chronic illness support program under the Arkansas Department of Human Services. **DIED ON THE CALENDAR/AMS SUPPORTED.**

SB 712 (Holiman, et al) Comprehensive Home Intravenous Drug Therapy Regulations. Provides for physician clinical management fees. Prohibits physician referrals to Home IV programs in which the physician has an ownership interest. **ACT 918/AMS NEUTRAL.**

SB 747 (Scott) Requires immediate signing of death certificates by charge physician upon pronouncement of death. **VETOED BY THE GOVERNOR/AMS OPPOSED.**



SB 778 (Bearden) Establishes penalties for unlawful practice of physical therapy. **DIED ON THE CALENDAR/AMS NEUTRAL.**

SB 779 (Hoofman) "Arkansas Health Insurance Pool Act." Creates uninsurable risk pool. **DIED ON THE CALENDAR/AMS SUPPORTED.**

SB 783 (Holiman) Establishes certification for pharmacist assistants. **ACT 922/AMS NEUTRAL.**

SB 807 (Todd) Removes reference to adult day care from definition of long-term care facility. **ACT 1090/AMS NEUTRAL.**

SB 826 (Lewellen) Provides \$200,000 for Health Department Outreach Services in nine eastern Arkansas counties. **PASSED THE SENATE. DIED ON THE HOUSE CALENDAR/AMS SUPPORTED.**

SCR 9 (Snyder) Declares a goal of increased fruit and vegetable consumption of 500 pounds per person, per year by the year 2000. **ADOPTED BY SENATE AND HOUSE/AMS SUPPORTED.**

SCR 14 (Holiman) Requests state agencies and health care provider organizations to agree on financial and statistical statements of fact before they are communicated to the General Assembly. **ADOPTED BY THE SENATE AND HOUSE/AMS SUPPORTED.**

## HOUSE BILLS

HB 1013 (Smith) Prohibits a child 12 years or younger from riding in back of open bed trucks. **DEFEATED IN THE HOUSE/AMS SUPPORTED.**

HB 1017 (McJunkin) Decreases from 10 to 3 days the filing period for a death certificate; decreases from 48 to 24 hours the period in which a medical certificate must be completed. **WITHDRAWN FROM FURTHER CONSIDERATION/AMS OPPOSED.**

HB 1037 (Roberts) Requires persons to keep firearms secure and non-accessible to persons under age 16. **WITHDRAWN FROM FURTHER CONSIDERATION/AMS SUPPORTED.**

HB 1103 (D. Wood) Authorizes counties and municipalities to create educational programs for youth accident prevention. **ACT 594/AMS SUPPORTED.**

HB 1107 (M. Wilson) Requires the awarding of attorney fees in certain civil actions. **DEFEATED IN THE HOUSE/AMS SUPPORTED.**

HB 1109 (Willems, Steele) Requires HIV testing of persons arrested for certain crimes. **WITHDRAWN FROM FURTHER CONSIDERATION/AMS SUPPORTED.**

HB 1123 (Deitz, Collier) Prohibits the distribution of methadone by state agencies. **WITHDRAWN FROM FURTHER CONSIDERATION/AMS NEUTRAL.**

HB 1183 (Purdum, et al) Appropriates \$650,000 for Claude Parrish (Harrison) Radiation Therapy Institute. **ACT 93/AMS SUPPORTED.**

HB 1238 (Blair, et al) Authorizes and encourages alternative dispute resolution in lieu of formal judicial process. **ACT 641/AMS SUPPORTED.**

HB 1262 (Roberts) Prohibits AID for Dependent Children (AFDC) payment to mothers who fail to avail themselves to prenatal care. **WITHDRAWN FROM FURTHER CONSIDERATION/AMS SUPPORTED.**

HB 1343 (Wyrick, et al) Authorizes court ordered AIDS testing for criminals transferring bodily fluids to law enforcement officers or EMT's. **ACT 438/AMS SUPPORTED.**

HB 1362 (George) Requires health care facilities to conduct "Newborn Infant Hearing Screenings." **ACT 1096/AMS SUPPORTED.**

HB 1376 (Steele, Purdum) Allows restricted drivers license for drivers with corrected vision less than 20/50; restricts driving to 20 mile radius; off interstates; in daylight; and not faster than 45 mph. **REFERRED TO JOINT INTERIM COMMITTEE/AMS SUPPORTED.**

HB 1417 (Roberts) Requires securing of firearms from children (same as HB 1037.) **DIED ON THE CALENDAR/AMS SUPPORTED.**

HB 1423 (Willems) Authorizes court to order HIV test for persons arrested for certain violations. **DIED ON THE CALENDAR/AMS SUPPORTED.**

HB 1441 (Flanagin) Increases population limits from 7,500 to 15,000 for communities to qualify for Rural Medical Clinic Loans. **ACT 762/AMS SUPPORTED.**

HB 1443 (Hogue) Exempts communication devices for persons with speech or hearing impairments from sales tax. **DIED ON THE CALENDAR/AMS SUPPORTED.**

HB 1446 (Sheid, et al) Appropriates \$650,000 for Radiation Therapy Institute in Mountain Home. **ACT 304/AMS SUPPORTED.**

HB 1460 (Landers, et al) Abolishes the Optometric Therapeutic Committee. (Same as SB 366) **ACT 211/AMS NEUTRAL.**

HB 1491 (Flanagin) Increases population limit from 8,000 to 15,000 for communities to qualify for Rural Medical Practice Student Loan and Scholarship Program. **DIED ON THE CALENDAR/AMS SUPPORTED.**

HB 1492 (Flanagin) Increases population limit from 8,000 to 15,000 for communities to participate in Rural Physician Recruitment and Retention Program. **ACT 763/AMS SUPPORTED.**

HB 1495 (Roberts) Requires insurance companies to reimburse "massage therapists" on an equal basis for their services as those registered under the Physical Therapy Act or Medical Practices Act. **DIED ON THE CALENDAR/AMS OPPOSED.**

HB 1527 (Dietz) Provides that anyone with HIV infection must inform a law enforcement officer before the officer transports him. **PASS THE HOUSE. DIED ON THE SENATE CALENDAR/AMS NEUTRAL.**

HB 1534 (Landers, et al) "An Act to Safeguard the Integrity of Women's Medical Decisions." Requires 24-hour waiting period for abortions; prescribes duties that a physician must perform in order that a patient may give her "informed consent." **PASS THE HOUSE. DO NOT PASS THE SENATE COMMITTEE/AMS NEUTRAL.**

HB 1556 (Pryor) List rules and regulations regarding "Do Not Resuscitate" orders for physicians and emergency medical personnel. **ACT 1101/AMS SUPPORTED.**

HB 1560 (Beatty, K. Wood) Authorizes court to order HIV test if sexual crime victim requests it. **ACT 616/AMS SUPPORTED.**

HB 1568 (Stewart) Physicians reporting of impaired drivers (same as SB 450 - except requires reporting.) **WITHDRAWN FROM CONSIDERATION/AMS OPPOSED.**

HB 1633 (Hogue, et al) Clarifies term "physician" (adds podiatry) to Good Samaritan Law. **ACT 1190/AMS NEUTRAL.**

HB 1640 (Henry) Requires CPR certification of staff as a condition of licensing child care facilities. **ACT 493/AMS SUPPORTED.**

HB 1689 (Hawkins) Provides civil immunity to persons providing emergency assistance at the request of government entities. **ACT 1191/AMS SUPPORTED.**

HB 1699 (Northcutt, et al) Prohibits possession, sale or use of bottle rockets. **DIED ON THE CALENDAR/AMS SUPPORTED.**

HB 1708 (Wingfield) Appropriates \$25,000 for Oriental Medicine Board operation. **REFERRED TO JOINT INTERIM COMMITTEE/AMS OPPOSED.**

HB 1731 (Dietz, Hogue) Prohibits physicians and physical therapists from engaging in referral for profit. **ACT 1210/AMS NEUTRAL.**

HB 1752 (Molinaro) Requires applicants for driver's license to report medical conditions that could affect the safe operation of a vehicle. **REFERRED TO JOINT INTERIM COMMITTEE/AMS NEUTRAL.**

HB 1753 (Molinaro) Requires traffic accident reports to include inquiries as to whether the accident was caused by a driver's lapse of consciousness or other physical condition. **REFERRED TO JOINT INTERIM COMMITTEE/AMS NEUTRAL.**

HB 1755 (Molinaro) Allows for revocation of drivers license if the driver has been involved in an accident caused by loss of consciousness. **REFERRED TO JOINT INTERIM COMMITTEE/AMS NEUTRAL.**

HB 1767 (Hendrix) Authorizes Arkansas Department of Corrections to develop in-house mentally ill treatment facility. **ACT 884/AMS NEUTRAL.**

HB 1770 (Gibson) Requires the Arkansas Department of Human Services to hold public hearings at least 20 days prior to the implementation of any rule, regulation or policy. **VETOED BY THE GOVERNOR/AMS SUPPORTED.**



HB 1774 (Flanagin, et al) Comprehensive Workers' Compensation Bill (Same as SB 550.) **DIED ON THE CALENDAR/AMS NEUTRAL.**

HB 1776 (J. Miller) Establishes student loan repayment plan for physicians joining AHEC's as a full-time faculty. **ACT 107/AMS NEUTRAL.**

HB 1796 (Smith, et al) Requires a 24-hour waiting period before receiving vasectomies; requires physician to provide information. **DIED ON THE CALENDAR/AMS NEUTRAL.**

HB 1797 (Flanagin) Requires the State Hospital to move to and combine with the Benton Services Facility. **ACT 1255/AMS NEUTRAL.**

HB 1798 (Flanagin) Requires U of A Board of Trustees to close one of the state's law schools. **DIED ON THE CALENDAR/AMS SUPPORTED.**

HB 1835 (Rice) Provides that if an x-ray is ordered for a patient who is moved to another medical facility before it is read and another x-ray is taken, the x-ray taken at the first facility need not be read, and the patient shall not be charged for its reading. **VETOED BY THE GOVERNOR/AMS NEUTRAL.**

HB 1872 (Stewart, Flanagin) Provides \$1,000 fine for selling, giving, or buying cigarettes for persons under 18 years of age. **WITHDRAWN FROM CONSIDERATION/AMS SUPPORTED.**

HB 1876 (Jt. Budget) UAMS appropriations for operations. Includes 6105 employees and 1075 extra help employees. \$76,533,411 from the U of A Medical Center Fund, and \$314,073,000 from cash funds for operating expenses. **ACT 948/AMS NEUTRAL.**

HB 1900 (Thicksten) Appropriates \$1,976,783 for financial assistance to students attending out-of-state schools for dental, optometry, osteopath, veterinary, podiatry and chiropractic training. **ACT 1259/AMS NEUTRAL.**

HB 1933 (McJunkin) Same as SB 700. **DIED ON THE CALENDAR/AMS SUPPORTED.**

HB 1947 (Mahoney, Newman) Appropriates \$3,500,000 for purchase of land, building and equipment for AHEC in El Dorado. **ACT 1122/AMS SUPPORTED.**

HB 1948 (Newman) Defines practice of chiropractic. **DIED ON THE CALENDAR/AMS NEUTRAL.**

HB 1953 (Pollan) Creates child abuse/rape/domestic violence section at UAMS. **ACT 887/AMS SUPPORTED.**

HB 1959 (Gibson) "Medicaid Fraud False Claims Act" **ACT 1299/AMS NEUTRAL.**

HB 1960 (Gibson) Provides reward of 10% of the aggregate penalty recovered, up to \$100,000, for reporting Medicaid fraud. **ACT 1300/AMS OPPOSED.**

HB 1961 (Gibson) Defines and specifies regulations and penalties for Medicaid fraud. **ACT 1291/AMS NEUTRAL.**

HB 1974 (Wilkins, et al) Requires notification within 24 hours to legal representative or guardian of long term care facility resident whenever a resident suffers an injury, receives outside medical care, or there is a significant change in physical or mental condition. **ACT 1123/AMS NEUTRAL.**

HB 1991 (Jt. Budget) Appropriates \$225,000 for Rural Medical Clinic Revolving Loan Fund. **ACT 705/AMS SUPPORTED.**

HB 1996 (Flanagin) Ensures that a child receives necessary medical treatment without regard to parents' practice of religious beliefs. **ACT 1126/AMS SUPPORTED.**

HB 2010 (McGee, et al) Provides \$200,000 for Arkansas Department of Health Outreach Programs, including expanded Norplant Family Planning Services. **ACT 992/AMS SUPPORTED.**

HB 2030 (Dietz) Provides that Medicaid drugs shall not be subject to therapeutic substitution. **DIED ON THE CALENDAR/AMS SUPPORTED.**

HB 2042 (Landers) Establishes regulations for Preferred Provider arrangements. **DIED ON THE CALENDAR/AMS OPPOSED.**

HB 2071 (Pryor) Clarifies the rights of health care providers to collect charges from third parties to the extent the charges exceed amounts reimbursed by Medicaid. **DIED ON THE CALENDAR/AMS SUPPORTED.**

HB 2086 (Fairchild) Defines Freedom of Information guidelines for records gathered and created by coroners. **ACT 1301/AMS NEUTRAL.**

HB 2087 (Fairchild) Requires state medical examiner to provide autopsy reports to the coroner in jurisdiction where death

occurred. **ACT 1304/AMS NEUTRAL.**

HB 2088 (Fairchild) Requires correction officers to report deaths to the coroner in jurisdiction in which death occurred. **ACT 1302/AMS NEUTRAL.**

HB 2089 (Fairchild) Establishes "Coroners Training Act." Prescribes qualifications and required training for coroners. **DEFEATED IN THE HOUSE/AMS NEUTRAL.**

HB 2099 (Brown, et al) Establishes "Arkansas Universal Health Care Act." **REFERRED TO JOINT INTERIM COMMITTEE/AMS OPPOSED.**

HB 2105 (Argue) Exempts eyeglasses, contact lenses, etc., from gross receipts and compensating use taxes. **WITHDRAWN FROM CONSIDERATION/AMS NEUTRAL.**

HB 2128 (Wagner, et al) Creates "Arkansas Athletic Trainers' Act." **DIED ON THE CALENDAR/AMS NEUTRAL.**

HMR 1002 (Schexnayder) Resolution memorializing Dr. Guy Robinson of Dumas. **ADOPTED BY THE HOUSE/AMS SUPPORTED.**

HCR 1008 (Flanagin, Smith) Request Joint Interim Committee on Public Health, Welfare and Labor to study the prescriptive authority of nurse practitioners, physician's assistants, allied health professionals and other non-physician health care providers and make recommendations to the 80th General Assembly regarding any provisions which might improve health care in rural Arkansas. **ADOPTED BY THE HOUSE AND SENATE/AMS NEUTRAL.**

HCR 1017 (Landers, et al) Expresses opposition to the proposal to remove HIV infection from the list of communicable diseases for the purposes of immigration. **ADOPTED BY THE HOUSE AND THE SENATE/AMS SUPPORTED.**

HR 1027 (Flanagin, Landers) Request study to determine feasibility of a competitive state Workers' Compensation fund. **ADOPTED BY THE HOUSE/AMS NEUTRAL.**

## **"1993 Doctors of the Day"**

Mary O. Aaland, M.D., Little Rock  
Leslie F. Anderson, M.D., Lonoke  
C. Stanley Applegate Jr., M.D., Springdale  
James A. Arnold, M.D., Fayetteville  
John W. Baker, M.D., Little Rock  
H. Kevin Beavers, M.D., Russellville  
Joseph M. Beck II, M.D., Little Rock  
Robert L. Berry, M.D., Little Rock  
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## Address by J. Larry Lawson, M.D.

1992-1993 President



Mr. Speaker, members of the House of Delegates, officers and guests. I appreciate the empathy of my predecessors as I finish this year's service as your President of the Arkansas Medical Society. This has been a year of joy and woe for all of us. The joys were watching the various programs of the society mature such as the Physicians Health Committee, Governmental Affairs, health insurance programs, the completion of the loan arrangement for the headquarters, Medical Education Foundation and Disease Prevention. The officers and counselors along with the House are largely responsible for these developments but the real workers and daily planners are the legendary names such as LaMastus, Wroten, Zeno, Mitchell and Waldo; the people we have grown to love and respect. This does not name everyone, but we should also remember those who have gone before us to get us where we are.

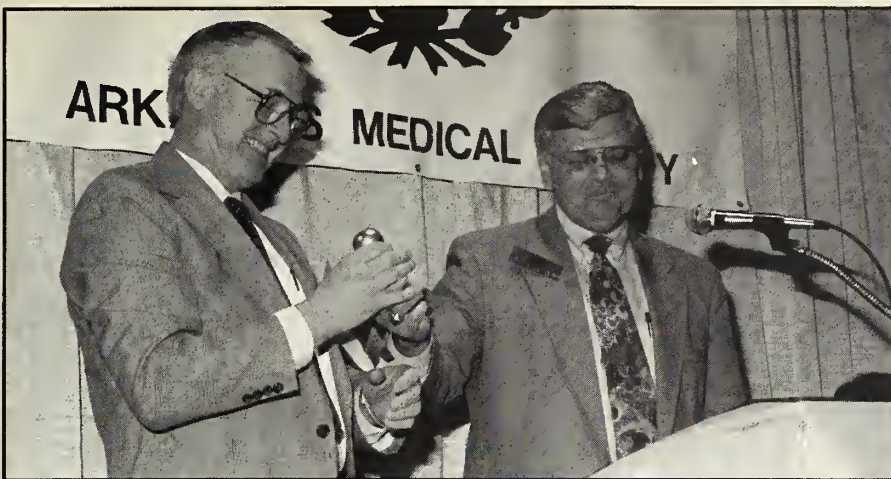
The woes come from recognition of our adversaries both from within and without organized medicine.

I speak first to those from within - the doctors in this country who see their patients too quickly to be a physician, the complacent physician who is otherwise too involved to help organized medicine, or worse, too uninformed to belong to their county, state, or national societies and is therefore, a parasite on those who do join.

I am also speaking of the featherbedding physician who overcharges - such as \$48,000 for augmentation mammoplasty - and the unscrupulous physician who

persistently practices on the dark edge of medicine. This minority receives the publicity and serves as grist for the cause-hungry politician. They are major contributors to the blight that we now suffer. If we are to survive as a profession rather than as a government utility, we will have to own up to the mote in our own eye. If we do not, our patients may see government owned, by-the-book medicine, and the best medical care may become black market medicine by physicians who have maintained their standards of care. Today, one of the fastest growing industries in Great Britain and Canada is private medicine. Is there a lesson we should have learned from Britain's 40 year-old failed social experiment? Our purpose is to combat disease and suffering but for the past 28 years, a great percent of our time has been consumed with our external adversaries - those who would control and practice medicine without paying the price of medical study. The third party payer, who began as a friend of the patient and an adjunct to the physician, has evolved into an adversary of the patient and a thorn in the side of the doctor. The third parties have historically been a welcome relief and I hope they will remain so. However, with continual meaningless phone calls from unknown faces, such as "need for more information", total loss of confidentiality and threats of nonpayment because of meaningless rules; our relationship has been stretched. Competition has been stifled by the very people who are calling for it. I hope the third parties change this relationship by their own volition. I am for





Ken LaMastus presents Dr. Larry Lawson with the "Golden Hitch Award".

third party payers and I want them to continue their work and prosper, but there needs to be a change in their direction before a comfort level can be re-established. In spite of our deep regard for our colleagues in the insurance industry, I do not see this change occurring from within the industry. All of us have known since we had our first job that whoever wrote the check, was the boss. Nothing has changed. Today, the third parties write the check. I am not opposed to them writing the check, but they need to write it to their customer, our patient, who should, in turn, pay the physician whom the patient has chosen to treat them. This would not only let the right people sign the checks but would also take the third party out of the business of making medical policy. This could be done today and physicians would again be able to compete with each other in the free market. Third parties would prosper, the patients would receive a fair value, and the physician would receive a just fee. The third parties should be reminded in the strongest of terms, that the physician and the patient generate their check - at least in a free market democracy. Surely even the bureaucrat must realize that someday they, or somebody they love, will become a patient. Will access to quality medical care become a patronage item?

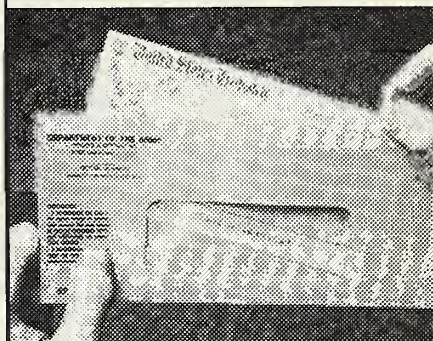
At this time, physicians refusing direct third party pay probably appears insane to many of us, but I am unable to see any other way to break the present crippling design. If you will recall, this radical thought worked well for us from 1776 to 1965.

It is my opinion that the doctors in this country are still a little too corpulent to play hard ball with this problem. When we dispose of our fantasy fees and other facades, we will see that this is the only way that we can resume control of our profession. I would like to admonish you to listen to some words from my old friend Theodore Roosevelt that I once read to the Council in lieu of an invocation, and challenge you to think of this in first person if you are really concerned about our destiny.

"It is not the critic who counts nor the man who points out how the strong man stumbled, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena; whose face is marred by dust and sweat and blood; who strives valiantly; who errs and comes short again and again; who knows the great enthusiasms, the great devotions and spends himself in a worthy cause; who at the best, knows in the end the triumph of high achievement; and who, at the worst, if he fails, at least fails while daring greatly so that his place shall never be with those cold and timid souls who know neither victory nor defeat."

Thank you.

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## Report of the 69th Annual Session Arkansas Medical Society Auxiliary

The 69th annual session of the AMSA was held in Hot Springs, April 15-17, in conjunction with the Arkansas Medical Society convention. Because of time constraints placed on this convention, the agenda for this House of Delegates was altered slightly. All business was conducted at one general session, Friday, April 16.

A leadership workshop for county presidents & presidents-elect was presented on Saturday morning, April 17th, and was followed by the Awards & Installation Brunch.

We were fortunate to have two special guests in attendance. Mrs. Mildred Taylor of Maryland, President-elect of Southern Medical Association Auxiliary, and Mrs. Barbara Tippins of Georgia, Nominated President-elect of the AMA Auxiliary, both presented wonderful addresses to our House of Delegates.

Special business voted on by the House of Delegates was approval of a recommendation to change the name of the AMS Auxiliary to the AMS Alliance. The first W. R. Brooksher Scholarship recipient, Mr. Daniel Ryan, was announced. During the Awards and Installation Brunch, special recognition was given to our 50 year members. A silent basket auction to benefit AMA-ERF was held on Friday evening and raised \$930.00.

This convention proved that our auxiliary can be flexible to fit the situations that arise and still allow time for camaraderie and entertainment.



*Sandy Harrison, 1992-93 President*



*Arleta Power, 1993-94 President*



*Barbara Tippins, President-elect of the AMA Auxiliary*



*Cindy Swicegood accepts the Viinnie Garrison Award for Sebastian County.*



*Cindy English accepts the Medical Heritage Award for Garland County.*



*(Center) Mary Ann Stallings accepts the Doctor's Day Award for Craighead/Poinsett.  
(Center bottom) Dawn Nowlin accepts the AMA-ERF Award for Washington County.*



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PLACE OF SERVICE CODE  
PRIMARY CARRIER

PRIOR AUTHORIZATION  
TYPE OF SERVICE CODES

SAME/SIMILAR INDICATOR  
PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING LEDGER CARDS

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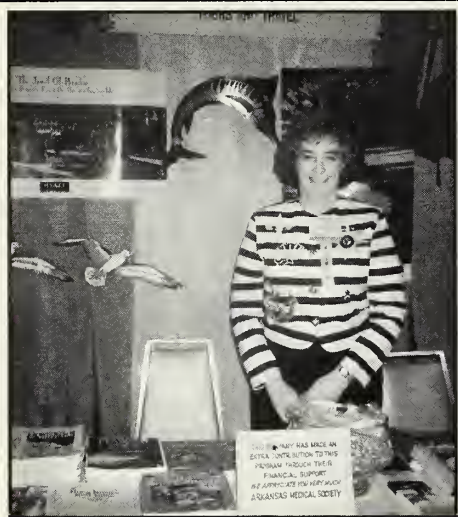


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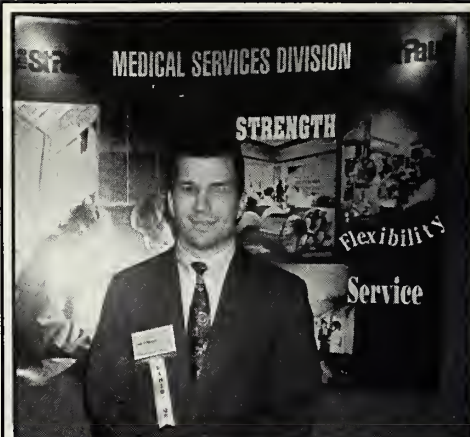


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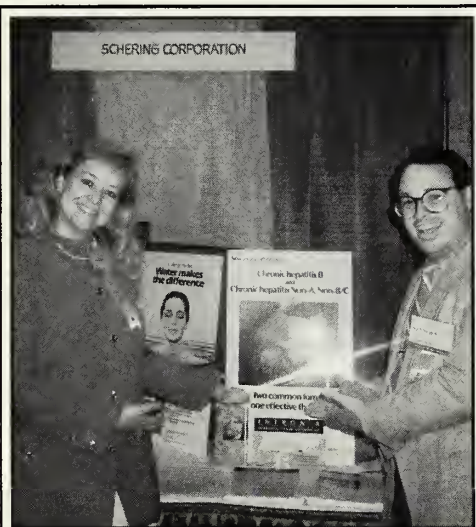
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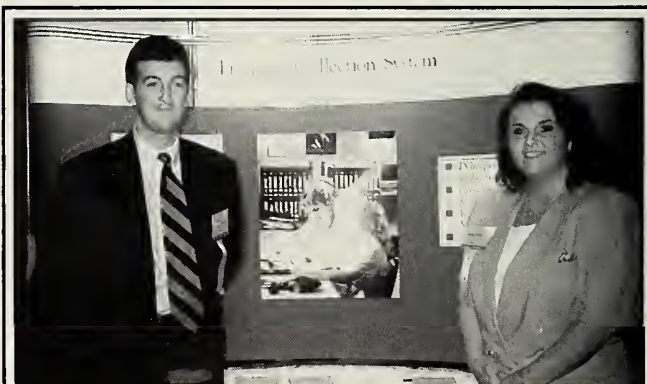


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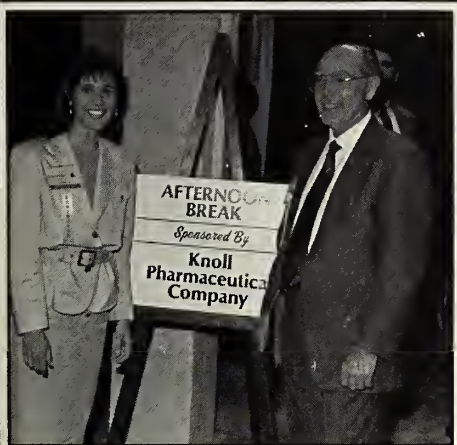




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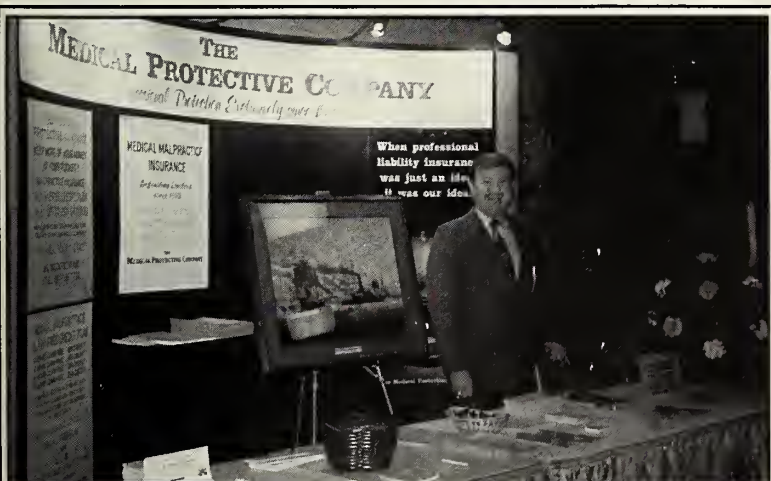
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# 1993 Grand Prize Winners



*Dr. Ben Saltzman, of Mountain Home, was the winner of the physician grand prize drawing at the AMS Annual Session. The grand prize was two round trip airline tickets to anywhere in the Continental U.S. The tickets were donated and presented by Ms. Lynn Hayes of Tours and Travel of Russellville.*

*Ed Baker (right), with The Rebsamen Insurance Company, was the winner of the exhibitor grand prize drawing held at the 1993 Annual Session. The exhibitor prize was \$200.00.*



*We'd like to thank Dr. Sanford Hudson (left) who announced the winners of the drawings with the assistance of AMS staff member Judy Hicks (center).*

## Thanks Exhibitors for Contributing all the Wonderful Prizes

*We had lots of great prizes contributed by our exhibitors to give away. (Below left) Dr. J. Mayne Parker won a VCR contributed by Communi-Care/Pro-Rehab, Inc. (Below right) Dr. Joe Stallings won a golf bag contributed by Continental Medical Systems.*



# *Fifty Year Club*



The Fifty Year Club is composed of physicians who, for the past fifty years, have loyally and effectively served the community and, by skill and devotion to high ideals, upheld and maintained the standards of the medical profession.

Dr. Joe Verser of Harrisburg, President of the Fifty Year Club, presided over the meeting. Physicians attending the Fifty Year Club Luncheon were Drs. John D. Ashley, Gilbert Dean, Ross Fowler, John Guenthner, Jim Huskins, E. L. Hutchison, Henry Kirby, Albert S. Koenig, Agnes Kolb, Jim McKenzie, Max Mobley, T. N. Rodman, Ben Saltzman, James Smith, Hermione Swindoll, H. W. Thomas, Joe Verser and Robert Watson.



# Minutes of the Arkansas Urologic Society

Spring Meeting - Saturday, April 17, 1993

The spring meeting of the Arkansas Urologic Society was called to order in the Venetian Dining Room of the Arlington Hotel in Hot Springs, Arkansas by Dr. Charles Brown, President. Dr. Tom Rohner, Professor and Chairman, Department of Urology, Penn State University was introduced by Dr. John Redman and a very dynamic and practical course on erectile dysfunction was presented by Dr. Rohner. The science and art treatment modalities were elaborated very well. The meeting began at 11:30 in the morning because Dr. Rohner had an early flight from Little Rock.

Members present included Dr. Ladd Scriber, Dr. Dwarka Mishra, Dr. Parthasarthy Vasudevan, Dr. Dennis Jacks, Dr. David Jacks, Dr. Morton Wilson, Dr. Steve Wilson, Dr. Bob Aspell, Dr. Fred Feder, Dr. Archie Hewitt, Dr. Allen McFarland, Dr. Charles Brown, Dr. Ken Meacham, Dr. Charles Logan, Dr. Alex Finkbeiner, Dr. Peyton Rice, Dr. Phillip Woodward, Dr. Ralph Downs and Dr. John Redman.

Mr. Lynn Zeno of the Arkansas Medical Society, was present and distributed information in regards to several changes and regulations in reference to the

Political Advisory Committee. The requirements for organization, structure and bylaws were presented. Federal guidelines have changed and the Arkansas Medical Society Political Action Committee has been acting in an advisory capacity with the other specialty sections.

Dr. Ladd Scriber reviewed the history of the Arkansas Urologic Society in regards to the Political Advisory Committee and made an outstanding presentation bringing the committee up to date in all the details of the workings of the organization. Dr. Steve Wilson made a motion, seconded by Dr. Phil Woodward, that we continue with the Governmental Affairs Committee, as we have in the past, and the motion passed unanimously after discussion.

Dr. Alex Finkbeiner made a motion, seconded by Dr. Ladd Scriber, that the organization and structure of the Arkansas Urologic Society Political Advisory Committee in conjunction with the Arkansas Medical Society be approved. After a discussion, this was approved unanimously by the membership.

Dr. Charles Logan recommended that \$3,000 be

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granted to the Arkansas Foundation for Urologic Diseases. We are approaching the \$25,000 mark which will make us eligible for a matching grant and a scholar which can be funded. Dr. Ladd Scriber made a motion that we fund \$3,000 to the American Foundation of Urological Diseases. This was seconded by Dr. Ken Meacham. The membership voted to pass this resolution.

Dr. Logan gave a report as the Area Representative for the South Central section of the American Urologic Association. Usage statistics for Medicare per 1,000 beneficiaries were given. The United States is divided up into 56 districts and Arkansas ranks number sixth in TURP and fourth in cystourethroscopy. PSA levels are fifth in the United States and these are related to the 1989 statistics.

Dr. Morton Wilson presented an update on the Arkansas Foundation for Medical Care. Dr. Jim Adamson is the new medical director of Blue Cross and Blue Shield. They have hired Dr. Bill Golden as the clinical coordinator who will make statistical analysis of the Arkansas practice.

Dr. Steve Wilson, immediate past President of the South Central section of the American Urologic Association greeted the membership and reminded everyone that the South Central meeting has been moved to Acapulco, October 4th thru the 7th. Mexico should be a wonderful time for everyone.

Dr. Charles Logan presented the results of the recent meeting with Dr. Jim Adamson of the Medical Services Review Board regarding laser prostatectomy. Representatives included Dr. Bob Bell, Dr. Alex Finkbeiner, Dr. Charles Logan. The meeting recommended that this not be reimbursed as a definitive prostatectomy code.

Called for old business and there was none.

Dr. Morton Wilson presented the HCFA modifications and they will eliminate the point systems. The hospital will be the Utilization Review Committee. Quality reviews will be eliminated and the quality assurance will be done more through the committees of the hospitals.

Dr. Ladd Scriber, Chairman of the Nominating Committee presented the nominations for President, Dr. Bob Aspell, Secretary-Treasurer, Dr. David Jacks.

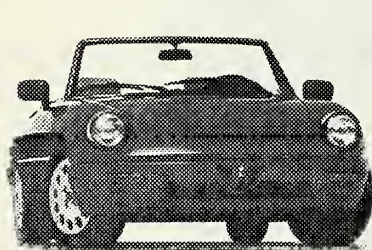
Dr. Ken Meacham expressed his appreciation for the coding meeting which was arranged by Dr. Jan Turley. He requested that these meetings be set up on a regular schedule, particularly after the Hillary report is finished.

Reminders for the fall meeting of the Arkansas Urologic Society will be at the Red Apple Inn in Heber Springs on October 22 through October 24. Dr. Paul Lange, Professor and Chairman, Department of Urology, University of Washington School of Medicine in Seattle, will be the visiting professor. All members are encouraged to attend with their families.

Special thanks to Ortho Pharmaceuticals and Mrs. Jo Ellen Childress for a generous contribution to the meeting.

Motion to adjourn was made at 1:45.

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Lawrence E. Drewrey, Camden  
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Eugene T. Ellison, Sr., Texarkana, TX  
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Laurence G. Fincher, Sr., El Dorado  
William Flanigan, Little Rock  
Robert E. Glasscock, Pine Bluff  
James H. Growdon, Little Rock  
Cecil E. Holcomb, Blytheville  
Anthony C. Hooper, Ballwin, MO  
Harmon Lushbaugh, Lowell  
Albert E. Martin, Jr., Bella Vista  
Robert R. Matthews, Little Rock  
Paul N. Means Sr., Malvern  
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# Arkansas HIV/AIDS Report

## 1983-1993

Arkansas: 1983 through April 25, 1993												
HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	19	32	49	216	251	437	421	408	127	1,960	85.00
	Female	1	1	6	27	39	72	89	83	28	346	15.00
AGE	< 5	0	0	1	1	2	9	14	8	0	35	1.52
	5-12	0	0	0	1	1	5	2	2	1	12	0.52
	13-19	0	0	0	8	8	14	20	26	5	81	3.51
	20-29	8	10	15	109	125	192	154	164	59	836	36.25
	30-39	7	15	22	86	105	206	219	185	62	907	39.33
	40-49	4	7	11	24	35	62	74	68	20	305	13.23
	> 49	1	1	6	6	12	19	23	38	8	114	4.94
	Unknown	0	0	0	8	2	2	4	0	0	16	0.69
RACE	White	16	24	47	171	178	353	312	302	98	1,501	65.09
	Black	4	9	8	70	107	153	195	179	54	779	33.78
	Other/Unknown	0	0	0	2	5	3	3	10	3	26	1.13
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	491	155	2,306	100%

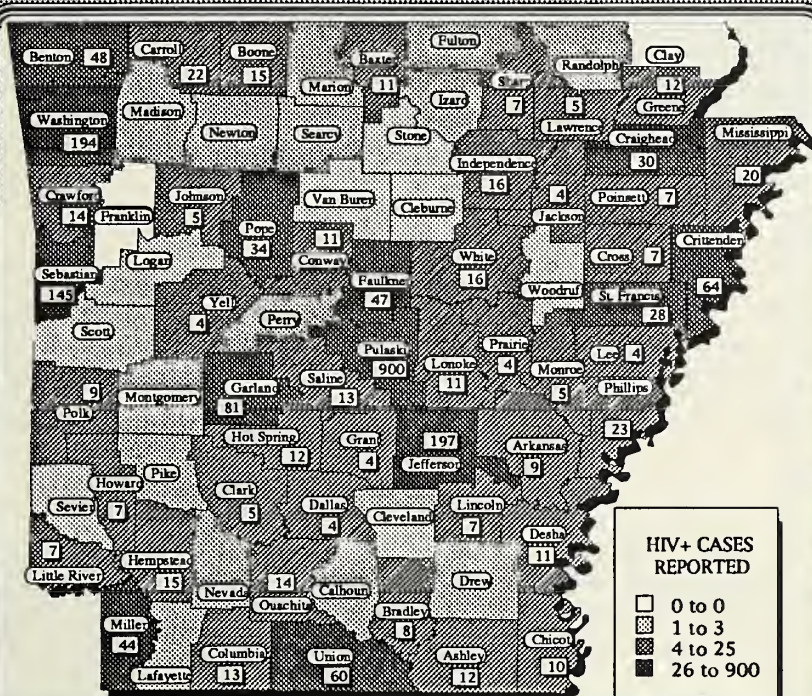
  

AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	164	992	88.02
	Female	1	0	4	6	10	20	25	35	34	135	11.98
AGE	< 5	0	0	0	1	1	6	6	3	0	17	1.51
	5-12	0	0	0	1	0	1	1	0	1	4	0.35
	13-19	0	0	0	0	0	4	3	2	4	13	1.15
	20-29	7	9	15	27	24	55	57	81	51	326	28.93
	30-39	3	13	23	36	41	78	80	128	90	492	43.66
	40-49	1	6	8	10	7	35	41	52	38	198	17.57
	> 49	1	0	4	8	7	11	13	19	14	77	6.83
	Unknown	0	0	0	0	0	0	0	0	0	0	0.00
RACE	White	9	22	43	61	58	141	134	207	147	822	72.94
	Black	3	6	7	20	21	47	66	74	48	292	25.91
	Other/Unknown	0	0	0	2	1	2	1	4	3	13	1.15
RISK	Male/Male Sex	7	17	31	59	50	118	118	177	105	682	60.51
	Injection Drug User (IDU)	0	2	10	4	11	18	28	40	27	140	12.42
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	12	93	8.25
	Heterosexual	2	0	2	3	6	10	10	22	18	73	6.48
	Transfusion	0	0	2	7	3	7	11	3	3	36	3.19
	Perinatal	0	0	0	1	1	6	6	3	1	18	1.60
	Hemophiliac	0	0	0	1	1	5	5	4	5	21	1.86
	Undetermined	0	0	1	2	2	8	6	18	27	64	5.68
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	198	1,127	100%

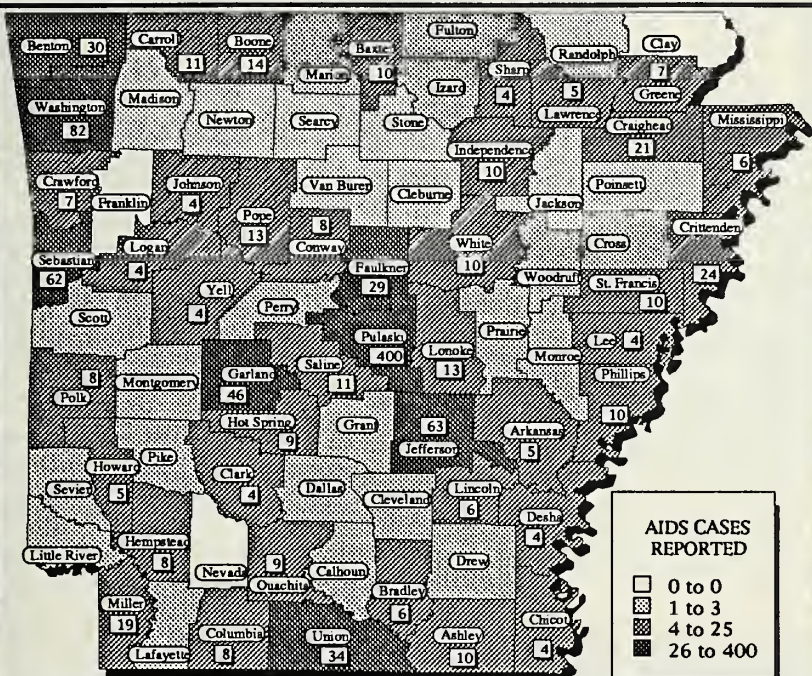
Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report 1983-1993



County of residence at the time of test for the 2306 Arkansans reported to be HIV+. (4/25/93)



Of the 2306 Arkansans reported to be HIV+, 1127 have been diagnosed with AIDS. (4/25/93)

## Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

## Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

## How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# New Members

## ALTHEIMER

**Jones, Bobby W.**, Internal Medicine. Born January 19, 1961. Medical education, UAMS, 1990. Internship/Residency, Eisenhower Army Medical Center, Ft. Gordon, Georgia, 1993.

## DEQUEEN

**Couture, Susan E.**, Internal Medicine/Pediatrics. Born June 26, 1960. Medical education, University of Texas Medical Branch, Galveston. Internship/Residency, UAMS, 1992. Board certified.

## FAYETTEVILLE

**Ureckis, David S.**, Family Practice. Born February 12, 1962. Medical education, UAMS, 1990. Internship/Residency, AHEC - Northwest, Fayetteville, 1993.

## FORT SMITH

**Roberts, Terence J.**, Radiation Oncology. Born March 11, 1963. Medical education, Johns Hopkins University School of Medicine, Baltimore, Maryland, 1987. Internship, UAMS, 1988. Residency, Johns Hopkins Hospital, 1991. Board certified.

**Porter, Neill C.**, Dermatology. Born September 7, 1962. Medical education, Louisiana State University Medical Center, Shreveport, 1988. Internship/Residency, University of Texas Medical Branch, 1992. Board certified.

## HARRISON

**Reese, Ronald R.**, Family Practice. Born December 19, 1946. Medical education, UAMS, 1974. Internship/Residency, UAMS. Board certified.

## HELENA

**Winston, William S.**, Family Practice. Born April 30, 1959. Medical education, Kirksville College of Osteopathic Medicine, Kirksville, Missouri, 1989. Internship, LSU, 1990. Residency, AHEC - Pine Bluff, 1992. Board certified.

## HOT SPRINGS

**Lennon, Yates A.**, OB/GYN. Born October 29, 1962. Medical education, East Carolina University School of Medicine, 1989. Residency, East Carolina University School of Medicine/Pitt County Memorial Hospital, 1993. Board eligible.

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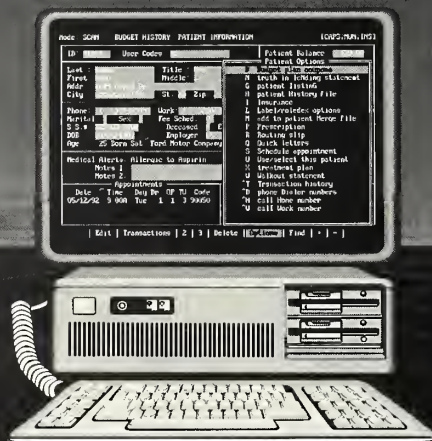
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## LITTLE ROCK

**Boos, Donald L. Jr.,** Anesthesiology. Born October 8, 1955. Medical education, Medical College of Ohio, Toledo, 1985. Internship, St. Luke's Hospital, Cleveland, 1986. Residency, University of Virginia, Charlottesville, 1989. Board certified.

**Fontenot, H. Jerrel,** Anesthesiology. Born March 4, 1954. Medical education, University of Mississippi, Jackson, 1986. Internship, University Hospital, Jacksonville, Florida, 1987. Residency, University of Florida, Gainesville, 1989. Board certified.

**Keith, Sharon C.,** OB/GYN. Born January 22, 1953. Medical education, UAMS, 1987. Internship/Residency, UAMS, 1991.

**Overacre, Robert L.,** Anesthesiology. Born February 15, 1958. Medical education, University of Oklahoma, 1985. Internship, Baptist Hospital, Oklahoma City, 1986. Residency, University of Oklahoma, 1989. Board certified.

**Snyder, Stephen D.,** Family Practice/Internal Medicine. Born April 19, 1952. Medical education, UAMS, 1978. Internship/Residency, UAMS, 1983. Board certified.

## SMACKOVER

**Davis, Richard K.,** Family Practice. Born March 20, 1957. Medical education, UAMS, 1983. Residency, AHEC, El Dorado, Arkansas, 1986.

## OUT OF STATE

**Jabbour, J. T.,** Pediatric Neurology, Memphis, Tennessee. Born August 5, 1927. Medical education, University of Tennessee, Memphis, 1951. Internship, Baylor Hospital, Dallas, 1952. Residency, University of Tennessee/University of Minnesota, 1961. Board certified.

**Stockinger, Fred S.,** Cardiovascular, Texarkana, Texas. Born August 25, 1941. Medical education, Indiana University School of Medicine, Indianapolis, 1966. Internship, Methodist Hospital, Grand Rapids, Michigan, 1962. Residency, University of Alabama, 1975. Board certified.

## RESIDENTS

**Pritchard, Sharon J.** Born August 8, 1966. Medical education, University of Texas Southwestern, Dallas, 1992. Internship, AHEC Northwest, Fayetteville, Arkansas.

## STUDENTS

Shelley Brown



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# In Memoriam

## Katheron H. Calcote

Katheron H. Calcote, of Lonoke, died Sunday, May 9, 1993. She was 68.

Survivor is her husband, Dr. Robert A. Calcote of Lonoke.

## Carole Hart Gilliland

Carole Hart Gilliland, of Little Rock, died Sunday, April 18, 1993. She was 57.

She was the widow of Dr. John C. Gilliland.

Survivors are four sons, Joseph Clayton Gilliland and John Campbell Gilliland III, both of Little Rock, Dabney Parrish Gilliland of Fort Smith, and Lee Barnett Gilliland of Scranton; a daughter, Chandler Polinsky of Fort Smith; a brother, Joe Hart of Memphis; two sisters, Marcia Roark of Lawrenceburg, Ky., and Cynthia McMillen of Nashville, Tenn.; and six grandchildren.

## Thomas G. Johnston, M.D.

Dr. Thomas G. Johnston, of Little Rock, died Saturday, May 8, 1993. He was 70.

Survivors are his wife, Amy Holcomb Johnston; a son, Thomas Glenn Johnston of Charlestown, Mass.; a daughter, Marcella Johnston of Little Rock; a stepson, Joe H. Ball of Nashville; a stepdaughter, Diane Williams of Little Rock; and three grandchildren.

## Harold D. Langston, M.D.

Dr. Harold "Chief" Langston, of Little Rock, died Monday, May 3, 1993. He was 72.

Survivors are his wife Carlyn Clark Langston; two sons, Marcus C. Langston of Fayetteville and Harold D. Langston, Jr. of Springdale; three daughters, Ann C. Cooper of St. Louis, Sandy Watson of Little Rock and Laurie Brooks of Fort Lauderdale, Fla.; and 10 grandchildren.

## Ruth Lesh, M.D.

Dr. Ruth Lesh, of Fayetteville, died Friday, April 16, 1993. She was 82.

Survivors are a son, Vincent Edward Lesh of California; a daughter, Susan Elizabeth Chadick of Fayetteville; a sister, Elizabeth Ellis of Fayetteville; three grandchildren and a great-grandchild.

## Marguerite Little

Marguerite Little, of Texarkana, Arkansas, died Sunday, April 18, 1993.

She was the widow of Dr. Arch A. Little.

## Mathilde Pool

Mathilde LeBeau Pool, of Little Rock, died Sunday, April 18, 1993. She was 86.

She was the widow of Dr. Chalmers S. Pool.

Survivors are nephews and nieces.

## Vernon Luther Toombs, M.D.

Dr. Vernon L. Toombs, of Gurdon, died Sunday, April 18, 1993. He was 79.

Survivors are five brothers, Jack Toombs and Julius Toombs, both of Gurdon, Charles Toombs of Texarkana, Texas, Billy Joe Toombs of Curtis and Ralph Toombs of Tyler, Texas; two stepbrothers, Lloyd Newton of Gurdon and Bill Newton of Curtis; and several nieces and nephews.

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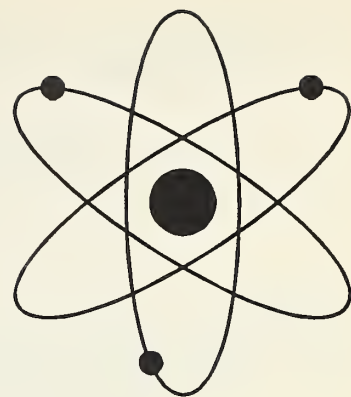
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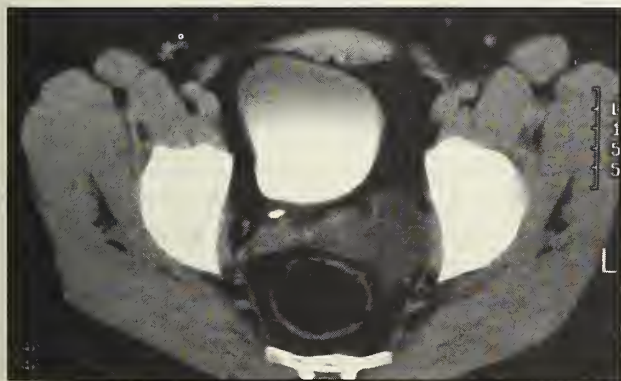
# Radiological Case of the Month



Steven R. Nokes, M.D.  
John E. Slayden, M.D.  
A. David Hall, M.D.  
Joe B. Pevahouse, M.D.  
D. Keith Mooney, M.D.  
Brian F. Sudderth, M.D.

## History:

A 21-year-old male presented with hematuria and left lower quadrant pain. A CT scan was obtained (Figures 1-3). Subsequent cystoscopy revealed an absent left ureteral orifice. A cystogram (Figure 4) was performed after unroofing the bladder.



Above top left: Figure 1  
Above top right: Figure 2  
Above left: Figure 3  
Right: Figure 4

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# Ectopic ureter with giant seminal vesicle cyst and atrophic left kidney.

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## Findings:

The CT scan reveals a normal right seminal vesicle adjacent to a markedly enlarged (5 cm) cystic left seminal vesicle. The left kidney is severely atrophic measuring 1 x 3 cm, but does excrete contrast. The cystogram demonstrates ectopic insertion of the ureter into the seminal vesicle cyst with atrophic calyces.

## Discussion:

Congenital seminal vesicle cysts represent a rare embryologic malformation, and are often associated with ipsilateral renal anomalies (agenesis, dysplasia or hypoplasia). The ureteral bud and seminal vesicle share a common origin from the mesonephric (Wolffian) duct. With isolated failure of development of the ureteral bud, renal agenesis occurs without genital tract abnormalities. Maldevelopment of the mesonephric duct in the 12th gestational week affects the ipsilateral seminal vesicle, vas deferens, ureter and kidney.

Presentation occurs in the third and fourth decades. Pain, dysuria, hematuria and infertility are common complaints. Most cysts are smaller than 5 cm.

The differential diagnosis of seminal cysts includes other deep pelvic cysts arising from the genital tract (prostatic, utricular or mullerian), as well as hydronephrotic pelvic kidneys, abscesses and benign or malignant tumors arising from the bladder, rectum, sacrum or lymph nodes.

In the past seminal vesiculography was an integral part of the workup, but required a high index of suspicion. Needle aspiration of the cyst is also diagnostic and yields spermatozoa. CT is the definitive noninvasive tool in the diagnosis. Treatment is restricted to symptomatic cases and consists of vesiculectomy with or without removal of the ipsilateral dysplastic or hypoplastic kidney.

## References:

1. Roehrborn CG, Schneider HJ, Rugendorff EW, Hamann W. Embryological and diagnostic aspects of seminal vesicle cysts associated with upper urinary tract malformation. *J Urol* 1986; 135:1029-1032.
2. Kenney PJ, Leeson MD. Congenital anomalies of the seminal vesicles: Spectrum of computed tomographic findings. *Radiology* 1983; 149:247-251.

---

*Editor: Steven R. Nokes, M.D., is affiliated with Radiology Consultants in Little Rock.*

*Contributor: John E. Slayden, M.D., is affiliated with Radiology Consultants in Little Rock.*

*Contributor: A. David Hall, M.D., is affiliated with Urology Associates in Little Rock.*

*Contributor: Joe B. Pevahouse, M.D., is affiliated with Renal Associates in Little Rock.*

*Contributor: D. Keith Mooney, M.D., is affiliated with Urology Associates in Little Rock.*

*Contributor: Brian Sudderth, M.D., is affiliated with the Bryant Family Clinic.*





# AMS Newsmakers

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**Dr. Neil Compton**, a retired Bentonville physician and Buffalo River advocate, has been presented the National Wildlife Federation's National Conservation Achievement Award.

He was honored at the 57th annual meeting in Arlington, Virginia. Compton is a charter member of the Arkansas Outdoor Hall of Fame.

**Dr. William E. Golden**, Little Rock, has accepted the position of clinical coordinator for the Arkansas Foundation for Medical Care Healthcare Quality Improvement Initiative. Golden will work with the administrators and medical staff of every Medicare participating hospital in Arkansas on specific clinical issues.

**Dr. Anna Riding**, of Pine Bluff, has been elected secretary, Southern Association for Family Practice.

The following AMS members are Physician Recognition Award Recipients:

Dr. William H. Benton, Little Rock  
Dr. James C. Bethel, Little Rock  
Dr. Raymond C. Bredfeldt, Fayetteville  
Dr. Edgar Scott Ferguson, West Memphis  
Dr. William C. Furlow, Conway  
Dr. James Presley Jackson, Little Rock  
Dr. Randy A. Jordan, Little Rock  
Dr. Robert W. Lehmberg, Little Rock  
Dr. John A. Mallory, Little Rock  
Dr. Joseph W. Matthews, Little Rock  
Dr. Hon-Kei Poon, Newport  
Dr. David H. Roberts, Mountain Home  
Dr. Daniel R. Stevenson, Jonesboro

## Medicine in the News

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### Health Care Access Foundation Update

As of May 1, 1993, the Arkansas Health Care Access Foundation has provided free medical service to 5,876 medically indigent persons, received 11,898 applications, and enrolled 24,318 persons.

The program has 1,576 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

### Pharmacy Board Issues Warning on Therapeutic Substitution

The Arkansas State Board of Pharmacy is finding evidence that some out-of-state mail order pharmacies are substituting totally different products from those originally prescribed.

The most recent example is using Chlorpheniramine 8mg capsules (one at bedtime, a 12 hour dose) Therapeutically substituted for Hismanal (a 24 hour dose).

Calls of this nature are not asking permission to use a generic equivalent but to Therapeutically substitute a totally different product.

The pharmacies say that their procedure is to call the physician and obtain permission for the Therapeutic Substitution. This is required by law.

Some physicians have complained that the did not

okay the Therapeutic Substitution and would not okay it, but the patient received the different product anyway.

### Arkansas Department of Health Receives \$100,000 Grant to Recruit Doctors

The Arkansas Department of Health has been awarded a \$100,000 grant by the Robert Wood Johnson Foundation to help recruit and keep doctors in rural and inner-city areas.

The Health Department was among agencies in 44 states that applied for \$16.5 million in available grants. Fifteen grants were awarded.

The grant is for planning during the next 15 months, according to Marc S. Kaplan of the Robert Wood Johnson Foundation, based in Princeton, N.J.

After the 15-month development phase, the Health Department's program will be evaluated. The foundation will then approve money to implement plans in 10 of the 15 states, Kaplan said.

The 10 winners will be eligible for three-year grants averaging \$800,000, Kaplan said.

He said plans include getting communities to help recruit physicians and removing barriers to practice by physician assistants, nurse practitioners and certified nurse midwives.

# Things To Come

## June 24-26

**Frontiers in Endourology.** Washington University Medical Center, St. Louis, Missouri. For more information, call (800) 325-9862.

## June 25

**American Medicine: Who Gets What? Who Decides? An Experiment in Ethics.** Hyatt Regency, Sacramento, California. For more information, call (916) 734-5390.

## June 25-27

**11th Summer Symposium in Internal Medicine.** Fort Magruder Inn & Conference Center, Williamsburg, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

## June 26

**Broaching the Biological Barriers to Transplantation: 4th Annual Rush Symposium on Transplantation.** The Inn at University Village on the campus of Rush-Presbyterian-St. Lukes' Medical Center. Registration fee: \$150. For more information, call (312) 942-6242.

## July 2-4

**23rd Annual Sports Medicine Symposium.** Sheraton Hotel, Atlantic Beach, North Carolina. Registration fee: \$75/physicians; \$25/resident or trainer. For more information, call (919) 240-1155 or (800) 624-8875.

## July 6-10

**16th Annual Flap Dissection Workshop.** Virginia Beach Conference Center, VA. Sponsored by the Eastern Virginia Medical School Office of Continuing Medical Education. CME credit offered. For more information, call (804) 446-6143.

## July 15-16

**Drug Utilization Review '93.** Sheraton Boston Hotel & Towers, Boston, MA. Sponsored by Infoline. For more information, call (508) 481-6400.

## July 15-17

**First Annual Mid-South Symposium on Cardiovascular Disease.** The Laurence A. Grossman Medical Learning Center, Saint Thomas Hospital, Nashville, Tennessee. Sponsored by the American College of Car-

diology. 18.5 Category I credit. For more information, call (800) 257-4739 (outside the U.S. and Canada, (301) 897-2695).

## July 17-23

**18th Annual National Wellness Conference.** University of Wisconsin-Stevens Point, Wisconsin. For more information, call (715) 346-2172.

## July 18-22

**Current Concepts in Cardiology.** Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Office of Continuing Medical Education, UC Davis Medical Center and School of Medicine. 19 hours Category I credit. For more information, call (916) 734-5390.

## July 21-25

**15th Annual National Lesbian and Gay Health Conference and 11th Annual AIDS/HIV Forum.** Houston, TX. Sponsored by The George Washington Univer-

### Arkansas Academy of Family Physicians' 46th Annual Scientific Assembly



### "Family Physicians - Shaping the Future of Health Care"

July 29 - August 1, 1993  
Little Rock, Arkansas

20 AAFP Prescribed Hours

For more information, call (501) 223-2272



University Medical Center Office of Continuing Medical Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of Continuing Medical Education, (202) 994-4285.

### **July 27-August 1**

**55th Annual Meeting of the International College of Surgeons-U.S. Section**, held in conjunction with the 33rd North American Federation Congress. Westin Hotel, Seattle, WA. For more information, call (312) 787-5274.

### **August 22-27**

**New Advances in Internal Medicine: Clinical Applications.** Hyatt Regency, Monterey, California. Sponsored by the Office of Continuing Medical Education, UC Davis Medical Center and School of Medicine. 25 hours Category 1 credit offered. For more information, call (916) 734-5390.

### **September 10-12**

**Frontiers in Endosurgery.** Washington University Medical Center, St. Louis. 18.5 credit hours Category I. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, contact program chairmen, Ralph V. Clayman, M.D. and Elspeth McDougall, M.D., at (314) 362-6893 or (800) 325-9862.

### **September 11-14**

**The Decade of the Brain: An International Conference.** The Omni-Shoreham, Washington, D.C. 28 Category I credit hours. For more information contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

### **September 17-18**

**Physician Executive Leadership.** Washington University Medical Center, St. Louis, Missouri. For more information, call (800) 325-9862.

### **September 18**

**Suicide.** St. Louis, Missouri. For more information, call Continuing Medical Education, Washington University School of Medicine, at (800) 325-9862.

### **September 20-22**

**Understanding Managed Care: An Introductory Program for New Managers in HMOs.** Loews Santa Monica Beach Hotel, Santa Monica, California. For more information, call (202) 778-3236.

### **October 1-3**

**International Liver Symposium.** Marriott Crystal Gateway Hotel, Arlington, Virginia. For more information, contact Daniel E. Reichard, George Washington University Medical Center, Office of CME, Washington, DC, (202) 994-4285.

### **October 6-14**

**Sixth Biennial Allergy Abroad Seminar.** Holland and Belgium. For more information, contact Phillip E. Korenblat, M.D. at Washington University Medical Center in St. Louis, Office of Continuing Medical Education, (314) 362-6893 or (800) 325-9862.

### **October 28-31**

**87th Annual Scientific Assembly of the Southern Medical Association.** New Orleans, Louisiana. Fee: \$75 member; \$200 non-member. AMA, AAFP, AOA offered - hours to be announced. For more information, call SMA Registration Department (205) 945-1840, (800) 423-4992 or FAX (205) 942-0642.

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# Keeping Up

## **Advances in the Management of Benign Prostatic Hyperplasia**

June 15, 6:30 p.m., Baxter County Regional Education Building, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Robert P. Nelson, Jr., M.D. Category I credit: 2.0.

## **1993 Spring Seminar, AHEC-Fort Smith**

June 29, 8:00 a.m.-4:45 p.m. & June 30, 8:30 a.m.-12:30 p.m., Holiday Inn Civic Center, Fort Smith. Sponsored by AHEC-Fort Smith. Category I credit to be announced, registration: \$75.00.

## **Mental Health Series:**

### **Co-Dependency: Family Needs in Recovery**

July 21, 12:00 noon-1:00 p.m., Center for Health Education, Dunkerton Room, St. Vincent Infirmary Medical Center. Sponsored by St. Vincent Infirmary Medical Center in cooperation with RESTORE and presented by Linda H. Fordyce, LCSW. One hour category I credit offered. Lunch provided. No fee, but registration required: 660-2810.

## **46th AAFP Annual Scientific Assembly**

July 29-August 1, Excelsior Hotel and Statehouse Convention Center, Little Rock. Sponsored by the Arkansas Academy of Family Physicians. CME credit offered. For more information, call (501) 223-2272.

## **Mental Health Series:**

### **Borderline Personality Disorder**

August 20, 12:00 noon-1:00 p.m., Center for Health Education, Dunkerton Room, St. Vincent Infirmary Medical Center. Sponsored by St. Vincent Infirmary Medical Center in cooperation with RESTORE and presented by Annette Slater, M.D. One hour Category I credit offered. Lunch provided. No fee, but registration required: 660-2810.

## **Baptist Memorial Medical Center's Summer Seminar**

August 21, 8:30 a.m.-12:30 p.m., Fairfield Bay Resort & Conference Center. Category I credit offered: 4 hours. Fee: \$20.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **FAYETTEVILLE-VA MEDICAL CENTER**

Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

CME Luncheon for Medical/Dental Staff, May 14 & 28, 12:30 p.m., AMI Ozark / Quapaw room. 1 hour Category I credit per luncheon.

## **Country Doctor of the Year**

America's finest rural physician will be honored as the "Country Doctor of the Year," a new award presented by the Country Doctor Museum in Bailey, North Carolina in association with Staff Care, Inc., an Irving, Texas-based interim physician staffing firm. Nominations for the award will be accepted through July 1, 1993 and may be submitted by physicians, health facility administrators, nurses, patients or relatives of the nominee. Those wishing to nominate a physician may obtain nomination forms by calling Staff Care at (800) 685-2272 or the Country Doctor Museum at (919) 235-4165.



#### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar*, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
*Genetics Conference*, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
*Infectious Disease Conference*, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
*Pediatric Grand Rounds*, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
*Pediatric Neuroscience Conference*, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
*Pediatric Pharmacology Conference*, 5th Wednesday, 12:00 noon, 2nd Classroom  
*Pediatric Research Conference*, 1st Thursday, 12:00 noon, 2nd Floor Classroom

#### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
*Journal Club*, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Chest Conference*, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Hematology-Oncology Conference*, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Cancer Center Team Conference*, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

#### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*Neurology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*ENT Conference*, 4th Friday, 11:30 a.m., Conference Room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Deep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

#### **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Chest & Problems Case Conference*, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Medicine Conference*, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Surgery Conference*, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Tumor Conference*, 1st Thursday, 12:00 noon, Assembly room. Lunch provided.  
*X-ray Case Conference*, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category of the Physician's Recognition Award of the American Medical Association.*

#### **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29

*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institut  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

#### EL DORADO-AHEC

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital



*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

#### **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

#### **FORT SMITH-AHEC**

*Advances in Plastic Surgery*, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Tuesdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center

#### **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

#### **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

#### **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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mittee to review ongoing activity in the HCQII program and give advice and feedback about new projects.

Critical elements of this process is the identification of issues for statewide quality improvement activity and the avoidance of punitive quality assurance citations. It is the expectation of the AFMC that local hospital administrative structures - from the hospital administration to institutional committees - will receive information derived from these projects and apply them in their ongoing local activities. Failure to incorporate and respond to information provided from these projects, over the longrun, could result in focused review by the more traditional PRO review mechanisms. It is hoped that such circumstances will be the exception rather than the rule as it will be good clinical practice for local institutions to embark upon voluntary quality assurance activities so that they can remain competitive in a reforming health care system.

In addition to the local projects, HCFA will organize national cooperative projects to examine specific clinical problems. For example, the Cardiovascular Cooperative Project (CCP) is now being field tested by several PROs prior to nationwide implementation. This project will assemble data concerning the process of cardiovascular care, focusing especially upon the management of myocardial infarctions and unstable angina. PROs using this methodology have found interesting data that have been of use to providers in their jurisdiction. It is likely that the Arkansas Foundation for Medical Care will be involved with the CCP sometime in 1994.

Educational feedback will be an important part of the HCQII. Efforts here will focus on informing hospital quality improvement committees about statewide findings as well as institutional specific data. HCQII team members will assist hospital personnel to incorporate this data into their institutional operations. In addition, the clinical coordinator will identify opportunities to reinforce clinical messages from these cooperative projects through educational initiatives of the UAMS Area Health Education Centers and statewide medical societies. AFMC newsletters as well as articles in *The Journal of the Arkansas Medical Society* may also prove effective. Every effort will be made to provide succinct and frequent reminders of HCQII findings to assist providers in incorporating new material into daily clinical practice.

Arkansas physicians should feel cautiously optimistic about the Fourth Scope of Work and the new directions of the PRO. These new efforts are geared to reduce single case critiques of physician management and, instead, focus on overall patterns of care by statewide physicians. Here is a real opportunity to reduce the hassle factor of daily practice while at the same time improving the delivery of care to the patients of Arkansas. We encourage your cooperation and support. The HCQII team welcomes questions and suggestions to make this new program effective and efficient.

Volume 90, Number 2 - July 1993



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# Latex: A New Occupational Hazard for Physicians

Martin P. Fiser, M.D.\*

Lawrence P. Landwehr, M.D.\*\*

## INTRODUCTION

Over the past few years latex allergy has become recognized as a serious medical problem. Reactions range from contact urticaria to anaphylactic death. These are IgE-mediated reactions rather than the common delayed-type hypersensitivity reactions associated with the contact dermatitis associated with latex gloves. Several high risks groups have been identified including physicians, nurses, dentists, patients with spina bifida, as well as patients undergoing barium enemas with latex-containing equipment. Recommendations for identification of latex sensitive individuals are discussed in addition to latex-avoidance procedures.

Latex is an ubiquitous material in the health care setting. Intravenous catheters, tubing, buretrols, injection ports, foley and nasogastric tubing, bougie catheters, condoms, masks, boots, gowns, and drapes all contain significant sensitizing amounts of latex. Physicians, nurses, dentists and an increasing number of other professions utilize latex gloves as part of universal precautions. Latex provides an essential yet inexpensive barrier between patients and healthcare workers. Ironically, this substance used to protect the patient and the physician from each other has become a significant cause of morbidity and mortality. Reports of anaphylaxis, asthma, and urticaria due to latex are becoming more common and will continue to escalate until awareness is raised and efforts are taken to confront this potentially serious problem.

Latex is a naturally occurring organic gum harvested from the milky sap of the rubber tree, *Hevea*

*brasiliensis*. It is the penultimate product in the manufacture of rubber. This complex substance is rich in the polymer cis-1,4 polyisoprene. Through slow heating in the presence of sulfur, or vulcanization, rubber attains its characteristic properties of elasticity, strength, and durability. The final product contains 2-3% protein. These chemicals added for processing are believed to be responsible for the well known contact dermatitis (type-IV hypersensitivity) associated with latex gloves. This type of latex hypersensitivity is usually mild and not life threatening. Recently, an increasing number of allergic reactions have been reported in the medical literature. These reactions include anaphylactic death, asthma, angioedema, urticaria and rhinoconjunctivitis.

In 1979, Nutter first reported a case of contact urticaria to rubber in a housewife wearing latex cleaning gloves.<sup>1</sup> Since 1987 over 600 serious reactions to latex including 16 anaphylactic fatalities have been reported to the FDA.<sup>2</sup> Exposure may occur topically, by inhalation or by direct intraoperative mucosal contact with latex containing instruments. Several high risk groups have been identified including, (1) children with spina bifida, (2) health care personnel who routinely use latex gloves, (3) patients receiving barium enema procedures with a latex balloon tip, (4) people with occupational exposure, such as individuals involved in the manufacture of latex gloves and (5) cases of unexplained intraoperative anaphylaxis.

Spina bifida patients may become sensitized to latex as a result of their need for routine catheterization of the bladder. The multiple surgeries often needed by this population may also increase the risk of exposure to sensitizing amounts of latex. These patients have an estimated 18-28% prevalence of latex hypersensitivity.<sup>3</sup> Slater reported two cases of pediatric spina bifida patients who had intraoperative anaphylaxis marked by hypotension, tachycardia, and sudden respiratory decompensation. He demonstrated in vitro basophil histamine release upon exposure to latex extracts in the

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\*\* Dr. Larry Landwehr is a pediatric resident at Arkansas Children's Hospital in Little Rock, Arkansas.

plasma of these patients.<sup>4</sup> Skin testing was also positive. Both patients had a history of urticaria after exposure to rubber products although one of the patients only had a history of periorbital and facial swelling after exposure to toy rubber balloons.

Health care personnel represent a large risk group. A Finnish study reported an overall incidence of latex allergy in hospital workers of 2.9%.<sup>9</sup> 7.4% of physicians and 5.6% of nurses in the surgical units were positive for latex hypersensitivity. Lagier surveyed 248 operating room nurses and found symptoms associated with latex gloves in 41%.<sup>5</sup> Skin prick testing was positive in 21 nurses (10.7%). A recent survey of the United States Army Dental Corps revealed a prevalence of latex glove allergy of at least 8.8%.<sup>6</sup> Settiple reported two cases of systemic reactions to latex in health care professionals. One case, a 30 year old surgical resident with a history of perennial allergic rhinitis and ankylosing spondylitis, began to develop a scratchy throat, postnasal drip, pruritus, erythema, dyspnea, wheezing and dizziness necessitating parenteral epinephrine and diphenhydramine upon donning rubber gloves. He had a 4+ positive skin prick test to latex and his radioallergen sorbent test (RAST) latex IgE specific antibody was fifty times the control.<sup>6</sup> Hong reported a case involving a 25 year-old female laboratory technician with a history of intermittent asthma and allergic rhinitis who developed intraoperative hypotension and asthma during a caesarean section.<sup>7</sup> She also had a history of post-coital pruritus when her husband used a condom. Postoperatively, she had a positive RAST and latex glove contact test demonstrating urticaria.

A recent report describes a set of six patients who developed symptoms of anaphylaxis during barium enemas.<sup>8</sup> One patient died. All the procedures involved the use of latex-cuffed rectal catheters. Three patients had latex-specific IgE by RAST and 4 had latex specific IgE by ELISA.<sup>12</sup>

A history of atopy imparts risk for latex hypersensitivity. The incidence of atopy in the general population is 15-20%. Sussman found that 57% of patients with known latex allergy had an atopic history—asthma, rhinitis or food allergy.<sup>9</sup> A University of Tennessee prospective study of 80 children referred to an allergy clinic for evaluation of inhalant allergy found 3 of 44 atopic patients, skin test sensitive to latex. None of the remaining 36 nonatopic patients were positive to latex. Two of the three children had a history of multiple surgeries, but none had any prior symptoms associated with latex.<sup>10</sup>

The recent escalation in the number of serious IgE-mediated hypersensitivity episodes has necessitated the search for the responsible antigen(s). Latex-associated contact dermatitis appears to be at least in part due to the chemicals used in the manufacture of rubber. However, these compounds are not thought to be causes

of IgE-mediated reactions. Cornstarch and talcum used in the packaging of gloves have been implicated but testing of these has shown no reactivity. Nonetheless, corn starch and talcum may serve as vehicles by which aerosolization of the latex antigen may occur. Latex is complex mixture of proteins, amino acids, lipids, and nucleotides. The principal protein, herein, is a low molecular weight (4730 Kd) protein and alone, is an unlikely candidate. Slater has identified a 14 kd peptide capable of binding latex-specific IgE from sensitive patients.<sup>11</sup> There have been reports of cross-reaction to banana antigen and anecdotal reports of cross reactions with avocado and hickory but conclusive evidence is lacking.

## SUMMARY AND CONCLUSIONS

Identification of latex sensitive individuals can be life saving. The American College of Allergy and Immunology has put forth the following recommendations:

- 1) Just as patients are routinely asked preoperatively about allergy to medications prior to treatment, a careful history should be obtained from every patient prior to any procedure involving contact with latex. Any patient who has a history of rash, itching, hives, rhinitis, swelling, or eye irritation or asthmatic symptoms after touching a balloon, rubber glove or any latex containing object is at risk for anaphylaxis. Previous medical history, of unexplained allergic or anaphylactic reactions during a medical procedure, may indicate sensitization.
- 2) Health care providers or other workers who give a history of only mild latex-glove eczema rarely have anaphylactic events. However, a history of work-related conjunctivitis, rhinitis, asthma, or urticaria may indicate allergic sensitization and increased risk for more severe reactions in the future.
- 3) The utility of screening tests for predicting anaphylaxis remains controversial. Suitable reagents for skin prick tests for latex are not commercially available at this time. Inasmuch as prick testing appears to carry a substantial risk of inducing anaphylaxis, this test must be considered experimental and it should only be done by experienced physicians with resuscitative equipment and personnel immediately available. Serum tests for latex-specific IgE, currently performed on a research basis at several laboratories, may confirm a suspected diagnosis in many cases but presently lack sensitivity to identify all patients with true latex allergy.

The following latex avoidance procedures should also be followed:

- 1) Latex sensitive patients should be protected from unintended exposures in the same manner as drug-sensitive patients. Possible methods include "latex-sensitive" wrist-bands and signage for hospitalized





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patients, as well as prominent labeling of patient charts. For patients with a prior history of anaphylaxis, a permanent "medic alert" wrist band should be considered.

2) Private offices, clinics and hospitals need to be cognizant of possible risks to latex sensitive patients and health care personnel. All products and medical procedures that come in intimate contact or are used by health personnel must be reviewed for possible latex content. A readily available master list for items "safe" for sensitive patients may help avoid unintended exposures.

3) Patients with myelomeningocele (spina bifida) should be referred for elective surgical procedures to centers which have latex-free surgical suites available. Other patients with a history suggesting a high risk of anaphylaxis should be evaluated and appropriately tested prior to surgery with recommendations to be made on case by case basis.

4) Health care personnel who show signs of latex contact dermatitis or latex hypersensitivity should be encouraged to avoid continued exposure to natural latex products and to use either synthetic latex or non-latex substitutes, since the natural history of this condition is not yet clear and at least some individuals have become anaphylactically sensitive overtime. Since all substitutes are not equally impermeable to blood-borne pathogens, care should be exercised in the choice in substitute gloves.

Diagnosis of latex hypersensitivity in suspected cases can be confirmed by latex skin prick testing. This should only be done in a setting where full resuscitation resources are available. RAST testing is not as sensitive as skin testing. Treatment of an acute hypersensitivity reaction to latex involves the usual therapy for an anaphylactic reaction, such as epinephrine, antihistamines, corticosteroids, and in severe cases, volume expanders, supplemental oxygen, and inotropic support.

Patients with known latex hypersensitivity may benefit from premedication prior to surgery. Steroids, H1 and H2 antihistamines, and bronchodilators may provide some benefit prophylactically. One report, however, describes anaphylaxis despite pretreatment.<sup>11</sup>

Condoms are an important source of latex in the general population. A few studies have investigated the role of condoms in latex hypersensitivity. Turjanmaa reports a 29% incidence of localized pain and inflammation during or after intercourse among condom users in a group of patients with a history of contact dermatitis caused by latex gloves.<sup>12</sup>

For many years we have known that latex surgical gloves or other latex-containing products can induce a delayed hypersensitivity reaction in the form of allergic contact dermatitis. While other immunologic responses

to latex have always existed, latex allergy as a systemic reaction has recently emerged as an important medical problem, especially in the context of precautions established to avoid contact with secretions from patients with HIV and other blood-borne diseases. Through heightened awareness, careful medical histories, improved screening techniques, and the development of low-antigen rubber products, this serious clinical problem can be reduced or avoided.

#### ALTERNATIVE GLOVES

<b>SYNTHETIC</b>	DERMADRENE (ANSELL, DOTHANAL) ELASTYRPEN (ALLERDERM LABS) NEOLON (BECTON DICKINSON)
<b>VINYL</b>	TRIFLEX (BAXTER PHARMACEUTICAL) TRUTOUCH (BECTON DICKINSON) SURGIKOS (SURGIKOS)
<b>LINED</b> (latex-lined)	INTEGRON (BECTON DICKINSON) NEUTRALON (JOHNSON-JOHNSON) BIOGEL (REGENT)
<b>TREATED</b>	ENDERMIC (BECTON DICKINSON)

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# From Years Past

*EDITOR'S NOTE: The following article, submitted by Joe Verser, M.D., of Harrisburg, ran in the Arkansas Gazette, on Sunday, December 5, 1948.*

## NEW NON-PROFIT GROUP HOSPITAL AND MEDICAL INSURANCE OFFERED

Employee groups may obtain non-profit hospital and medical insurance in Arkansas after January 1.

The service later will be extended to smaller rural groups and communities, a member of the Organization Committee said yesterday.

The service will be offered by the Arkansas Medical and Hospital Service, Inc. The corporation is sponsored by the American Medical Society, the Arkansas Hospital Association and the Arkansas Farm Bureau Federation.

It is a non-profit organization. It will underwrite hospital expenses up to \$6 a day for 30 days a year, and cover a maximum of \$175 in surgical expenses.

Each type of operation is classified, and benefits vary according to seriousness. Any difference between the surgeon's charges and the amount specified by the insurance must be paid by the policyholder.

Premiums are : For individuals, \$1 a month for hospital benefits; \$1.85 a month for hospital and surgical benefits.

For families (regardless of size), \$2.50 a month for hospital benefits, \$4.35 a month for both hospital and surgical benefits.

The corporation will start offering memberships to groups of employees on or soon after January 1, and later will extend the service to rural groups and communities, a Joint Committee of the incorporators meeting at the Albert Pike hotel, said yesterday.

### Blue Cross to Consider

The national Blue Cross, hospital organization, is expected to consider Arkansas for membership at a meeting at Chicago Thursday, said Jack L. Redheffer of Kansas City, the organization's executive director. The American Hospital Association

trustees are expected to take similar action at a meeting at Chicago Saturday, he added. Approval by the two groups would mean that policy-holders in Arkansas would be eligible for hospitalization and surgery at all points in the United States where the Blue Cross and Blue Shield are represented.

John A. Rowland of Trinity hospital, a committee member, said that the plan "will be of great help to industry, labor and farm groups in solving the problem of the cost of illness."

### 18 Incorporators

The organization's incorporators include six medical doctors, six hospital officials and six business and professional representatives. They are:

Dr. Ellery C. Gay, Little Rock, Arkansas Baptist hospital; Marvin Altman, Fort Smith, Sparks Memorial hospital; Harvey C. Couch Jr., Little Rock, Union National bank; Dr. R. C. Dickinson, Horatio; S. P. Dixon, Little Rock, state deputy commissioner of labor; Dr. Lippert S. Ellis of Fayetteville, dean of University of Arkansas College of Agriculture; Waldo Frasier, Little Rock, executive secretary of Arkansas Farm Bureau Federation; Dr. M. C. Hawkins of Searcy, Hawkins Clinic hospital; Msgr. John J. Healy, Little Rock, director Arkansas Catholic hospitals; John A. Gilbreath, Little Rock, Arkansas Baptist hospital; Dr. Charles R. Henry, Little Rock; Miss Regina Kaplan, Hot Springs, Leo N. Levi Memorial hospital; Dr. P. W. Lutterloh, Jonesboro; Dr. Roy I. Millard, Russellville; Mr. Rowland; W. M. Shepherd, Little Rock, industrial director of Arkansas Power and Light Co.; Dr. Joe Verser, Harrisburg, Verser Clinic hospital, and Edward L. Wright, Little Rock, Buzbee, Harrison and Wright.

Mr. Redheffer has been employed as the corporation's executive director. Offices are located in Room 815, Rector building.





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# Loose Body of the Elbow Mimicking Tumor

Joan B. Krajca-Radcliffe, M.D.\*

Richard W. Nicholas, M.D.\*\*

Hemendra R. Shah, M.D.\*\*\*

## ABSTRACT

Distinguishing between calcific soft-tissue masses and intra-articular loose bodies about the elbow can be difficult. We present the case of a 59-year-old woman with a slowly enlarging soft-tissue mass about the elbow. History, physical examination, and diagnostic studies did not establish a definite diagnosis, nor did they rule out the possibility of a neoplastic process. Excisional biopsy revealed a loose body contained in a cystic mass with elbow joint communication.

## HISTORY

A 59-year-old woman presented with a soft-tissue mass medial to the distal right humerus. She first noted the lesion approximately eight months prior to presentation when the mass gradually enlarged and caused increasing pain and paresthesias in her right upper extremity. She had no prior history of trauma to this region. On physical examination, a firm, mobile mass approximately 3 cm in diameter was palpable near the region of the medial humeral condyle. The mass was tender to palpation and was edematous with regions of hard irregularities. It did not seem to be transfixed to bone. Radiographs of the right elbow showed a calcified mass in the soft tissues adjacent to the medial distal humerus with possible attachment to or arising from cortex (Fig. 1). Computed tomography (CT) indicated a region of fluffy soft-tissue calcification adjacent to the medial region of the distal humerus without any broad-base bony attachment, but it was difficult to tell whether



Figure 1: Anterior-posterior (left) and lateral (right) radiographs of the right elbow demonstrating a calcific mass in the soft tissues adjacent to the medial distal humerus.

it arose from bone, periosteum, or adjacent soft tissue (Fig. 2). An excisional biopsy was performed.

## DIAGNOSIS

Diagnosis: Loose Body of the Elbow Mimicking Tumor. The lesion was completely removed at the time of surgery. Dissection revealed a cystic mass with joint communication and no attachment to the humerus. This cavity contained a large solitary calcified mass (Fig. 3). Synovial inflammation was present in the region about the mass.

## DISCUSSION

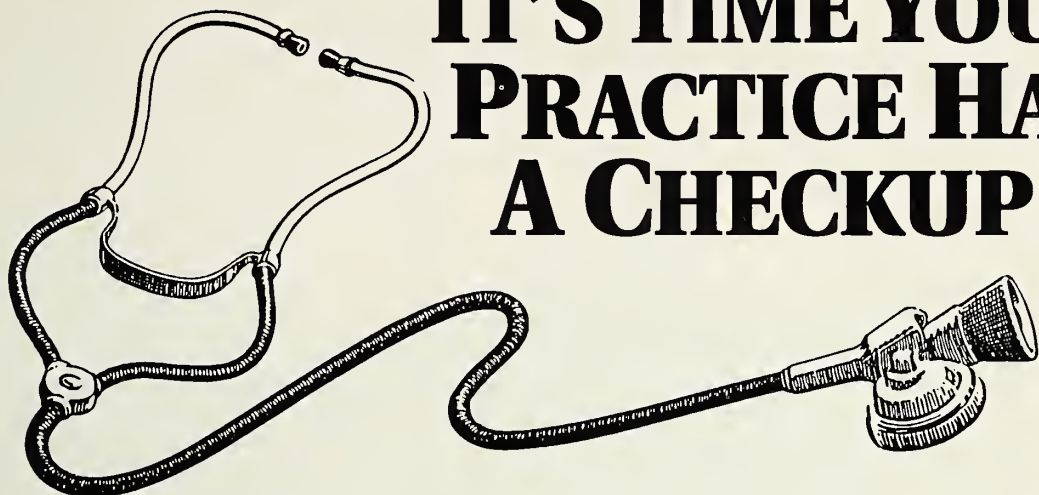
The clinical presentation of a slowly-enlarging mass arouses suspicions of a neoplastic process. The differential diagnosis for a calcifying soft tissue mass is broad

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\*\*\* Dr. Hemendra R. Shah is in the Department of Radiology, University of Arkansas for Medical Sciences.





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and when occurring near a joint includes reactive processes such as myositis ossificans, calcified lymphadenitis, and heterotopic ossification. Neoplastic causes include chondromas and other benign lesions which may contain dystrophic calcifications as well as malignancies such as chondrosarcomas and synovial sarcomas. Intra-articular loose bodies may arise from several conditions, including acute osteochondral fractures, chronic trauma, osteochondritis dissecans, synovial chondromatosis, and degenerative arthritis. As previously noted by Bell,<sup>1</sup> differentiating an intra-articular loose body from a calcific soft tissue lesion about the elbow can be difficult, especially if the mass appears to be extra-articular and not attached to the bone. The pattern of calcifications in this case as seen on both the plain



Figure 2: Transverse CT image showing soft-tissue calcification adjacent to the medial distal humerus.

films and CT scan suggests a cartilaginous lesion. The fluffy soft-tissue calcification adjacent to bone, without a known history of trauma, led us to pursue a diagnostic work-up for an extra-articular tumor, rather than to utilize contrast arthrography, the recommended method for demonstrating loose bodies.<sup>1,2</sup> Such a study would have been expected to fill the bursal cavity surrounding the loose body, thus demonstrating its connection to the elbow joint.

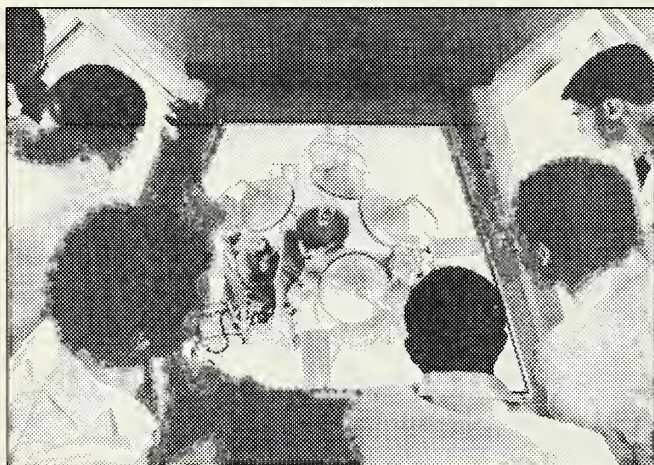
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Figure 3: The resected lesion showing a cystic mass containing a solitary calcified loose body.

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# New AIDS Case Definition

Source: Arkansas Department of Health

A new expanded AIDS surveillance case definition was implemented by the Centers for Disease Control January 1, 1993. Under this new definition, any person greater than 12 years of age with documented HIV infection along with CD4+ lymphocyte count less than 200 or with total lymphocytes less than 14 percent will be reportable as an AIDS case.

In addition to the 23 AIDS-defining conditions from the 1987 case definition, three new clinical conditions have been added. Conditions of invasive cervical cancer, pulmonary tuberculosis or recurrent pneumonia (two or more episodes within a 12-month period) in persons with documented HIV infection will also meet AIDS case definition.

Under this new definition using the CD4 lymphocyte counts, the date of AIDS diagnosis will be retroactive to the CD4 test date. The initial impact of the new case definition is expected to create a significant increase in the number of reported AIDS cases nationwide, primarily due to this addition of severe immunosuppression. The addition of pulmonary TB, recurrent pneumonia and invasive cervical cancer will have a much smaller impact in the number of new cases reported.

In Arkansas, the expanded case definition quadrupled the state's monthly average of AIDS case reports for January. An all-time high of 102 AIDS cases were reported for that month. The previous record high was 50 cases reported in September, 1992. At the end of December, 1992 Arkansas' AIDS case rate was 11.7 per 100,000 population and ranked 18th highest in the country. The case rate jumped to 15.2 per 100,000 after the January cases were tabulated, ranking Arkansas number 15.

Due to this immediate impact, CDC estimates a potential increase of about 75 percent in AIDS cases reported in 1993. Additionally, increases in case rates are expected in the 24 states that currently have laws mandating HIV reporting by name, since those states

have a large reservoir of HIV+ cases that can easily be reviewed to determine if they meet the new definition. Arkansas law has required HIV reporting by name since 1988.

## ARKANSAS RANKS 15TH IN AIDS CASES PER CAPITA

CDC also anticipates that the early effects of the expanded surveillance will be greater than the long-term effects because prevalent as well as incident cases of immunosuppression will be reported. In subsequent years, the effect on the number of reported AIDS cases is expected to be much smaller.

Due to this new definition, laboratory reports of positive HIV tests and CD4 test results is of critical importance to maintaining effective HIV / AIDS surveillance. CD4 test results of all HIV+ persons reported will be monitored from laboratories, public health agencies and health care settings.

CDC funding of surveillance cooperative agreements is dependent on the recipients ability to ensure the physical security of case reports and on state policies or laws to protect the confidentiality of persons reported with AIDS. Failure to ensure the security and confidentiality of all identifying information collected as part of AIDS or HIV surveillance activities will jeopardize federal surveillance funding.

The Arkansas Department of Health and CDC have implemented procedures and policies to maintain confidentiality and security of HIV / AIDS surveillance data. These efforts include a federal assurance of confidentiality, the removal of all names before coded records are sent to CDC, strict guidelines for release of data, and the inclusion of confidentiality and security safeguards as evaluation criteria for federal funding of state HIV / AIDS surveillance activities. These strict criteria would continue to apply to cases reported under the expanded definition.



In order to assure swift implementation of the new case definition, the Arkansas AIDS Surveillance Unit is in the process of modifying the new CDC AIDS case report form. This new form will be used for collection of data and reporting of persons who meet AIDS case definition as well as those persons with asymptomatic HIV infection. These new report forms will be ready for distribution in early spring. Copies may be ordered in early spring. Copies may be ordered by calling the Surveillance Unit at (501) 661-2387 or 661-2323.

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## AIDS CASE DEFINITION

Effective January 1, 1993 the AIDS case definition of the Centers for Disease Control was amended to include HIV infection and any of the following clinical conditions:

- Candidiasis of bronchi, trachea or lungs
- Candidiasis, esophageal
- Cervical cancer, invasive\*
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal (>1 month duration)
- Cytomegalovirus disease (other than liver, spleen, or nodes)
- Cytomegalovirus retinitis (with loss of vision)
- HIV encephalopathy
- Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis, or esophagitis
- Histoplasmosis, disseminated or extrapulmonary
- Isosporiasis, chronic intestinal (>1 month duration)
- Kaposi's sarcoma
- Lymphoma, Burkitt's (or equivalent term)
- Lymphoma, immunoblastic (or equivalent term)
- Mycobacterium avium complex or M. Kansasii, disseminated or extrapulmonary
- Mycobacterium tuberculosis, any site (pulmonary\* or extrapulmonary)
- Mycobacterium, other species or unidentified species, disseminated or extrapulmonary
- Pneumocystis carinii pneumonia
- Pneumonia, recurrent\*
- Progressive multifocal leukoencephalopathy
- Salmonella septicemia, recurrent
- Toxoplasmosis of brain
- Wasting syndrome due to HIV (fever or diarrhea and loss of weight >10% baseline)

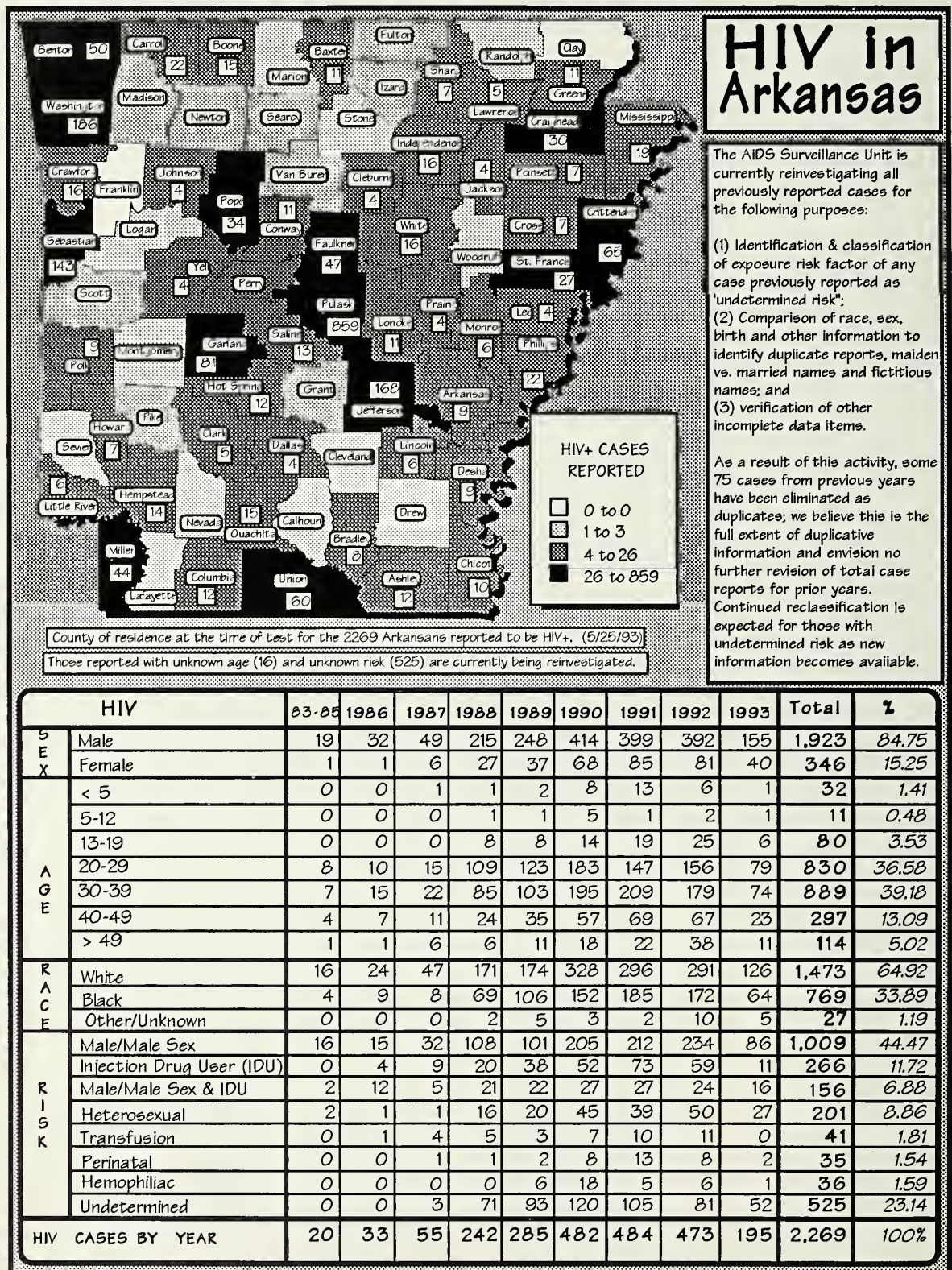
Documented CD4+ T-lymphocyte count <200/ $\mu$ l or % of total lymphocytes <14%\*

\*Added in 1993 expansion of AIDS surveillance case definition.

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991. Reporting is required at the time an individual tests positive for HIV and again when the individual meets AIDS case definition. Reporting is required by physicians, nurses, hospital infection control practitioners, laboratory directors, medical directors of nursing homes, medical directors of home health agencies, clinic administrators, program directors of State agencies, and other persons as required by the rules and regulations of the Department of Health.

# Arkansas HIV/AIDS Report

## 1983-1993

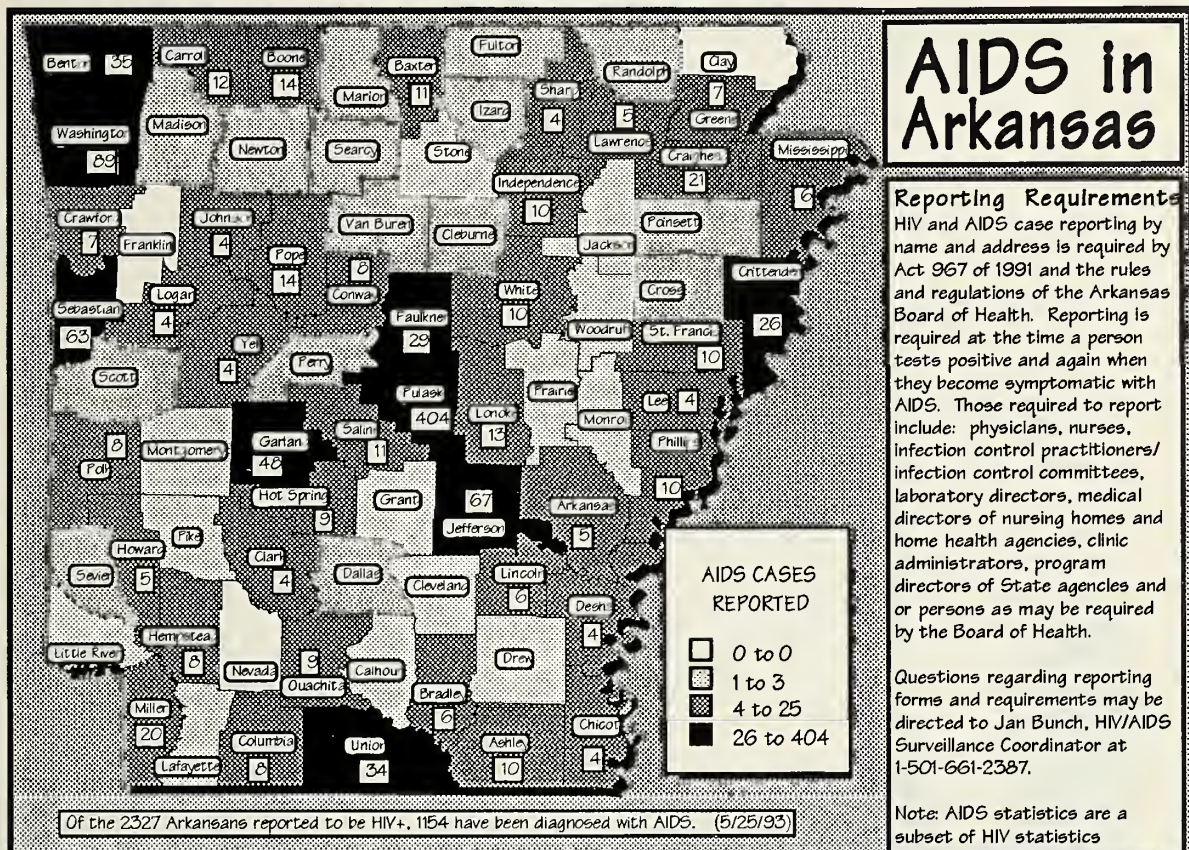


Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1993



AIDS		83-85	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	186	1,014	87.87
	Female	1	0	4	6	10	20	25	35	39	140	12.13
AGE	< 5	0	0	0	1	1	6	6	3	0	17	1.47
	5-12	0	0	0	1	0	1	1	0	1	4	0.35
	13-19	0	0	0	0	0	4	3	2	4	13	1.13
	20-29	7	9	15	27	24	55	57	81	60	335	29.03
	30-39	3	13	23	36	41	78	80	128	102	504	43.67
	40-49	1	6	8	10	7	35	41	52	43	203	17.59
	> 49	1	0	4	8	7	11	13	19	15	78	6.76
RACE	White	9	22	43	61	58	141	134	207	165	840	72.79
	Black	3	6	7	20	21	47	66	74	56	300	26.00
	Other/Unknown	0	0	0	2	1	2	1	4	4	14	1.21
RISK	Male/Male Sex	7	17	31	59	50	120	120	178	123	700	60.66
	Injection Drug User (IDU)	0	2	10	4	11	18	29	43	33	146	12.65
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	13	94	8.15
	Heterosexual	2	0	2	3	6	10	9	25	26	81	7.02
	Transfusion	0	0	2	7	3	7	11	3	2	35	3.03
	Perinatal	0	0	0	1	1	6	6	3	1	18	1.56
	Hemophiliac	0	0	0	1	1	5	5	4	5	21	1.82
	Undetermined	0	0	1	2	2	6	4	11	22	59	5.11
AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	225	1,154	100%

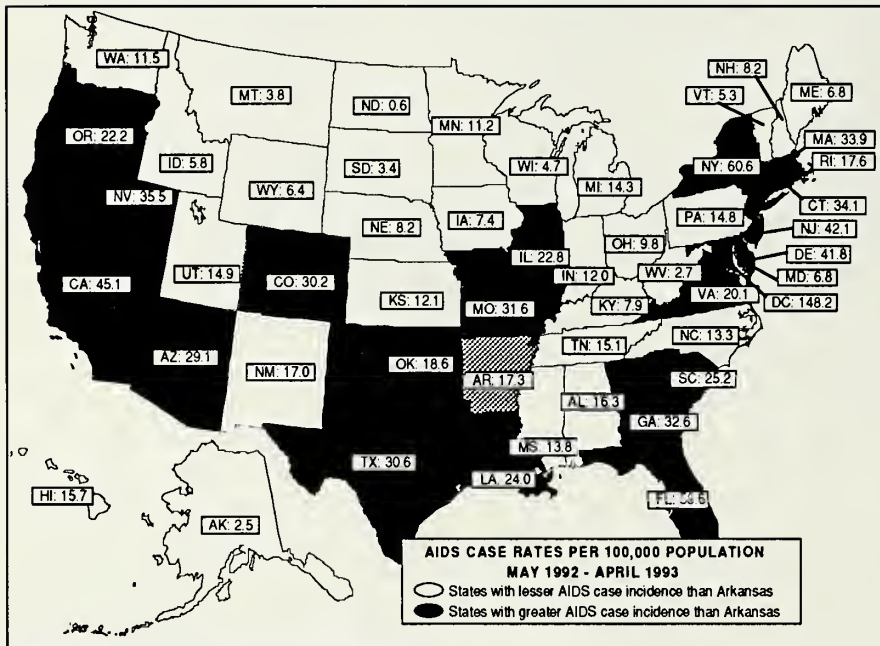
Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report 1983-1993

## Arkansas and the Nation

	Arkansas	United States
Total AIDS Cases Reported, previous 12 months	415	74,510
AIDS Case Rate per 100,000 population	17.3	28.7
Cumulative AIDS Case Reports: 1983 - PRESENT*	1,154	296,412
Adult	1,133	291,891
Pediatric	21	4,521
Deaths: 1983 - PRESENT*	539	171,890
Adult	531	169,623
Pediatric	8	2,267
Mortality Rate	46.7%	58.0%



### CASE RATES PER 100,000

DC	148.2
NY	60.6
FL	58.6
CA	45.1
NJ	42.1
DE	41.8
NV	35.5
CT	34.1
MD	33.9
GA	32.6
MO	31.6
TX	30.6
CO	30.2
AZ	29.1
SC	25.2
LA	24.0
MA	23.2
IL	22.8
OR	22.2
VA	20.1
OK	18.6
RI	17.6
AR	17.3
NM	17.0
AL	16.3
HI	15.7
TN	15.1
UT	14.9
PA	14.8
MI	14.3
MS	13.8
NC	13.3
KS	12.1
IN	12.0
WA	11.5
MN	11.2
OH	9.8
NH	8.2
NE	8.2
KY	7.9
IA	7.4
ME	6.8
WY	6.4
ID	5.8
VT	5.3
WI	4.7
MT	3.8
SD	3.4
WV	2.7
AK	2.5
ND	0.6

	Arkansas	United States
Men who have sex with men	60.7%	56.3%
Heterosexuals who use Injected Drugs	12.7%	22.7%
Men who have sex with men and use Injected Drugs	8.2%	6.3%
Heterosexual contact with a person at risk	7.0%	6.4%
Transfusion with blood products	3.0%	2.0%
Infants born to HIV-infected mothers	1.6%	1.4%
Persons with hemophilia	1.8%	0.9%
Risk unknown at this time	5.1%	4.0%

\* Arkansas statistics are valid through May 25, 1993; total U.S. cases and case rates are correct through April 1993; total U.S. deaths and other national statistics are current through March 30, 1993.

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# New Members

---

## ARKADELPHIA

**Jansen, Mark T.**, Family Practice. Born September 30, 1955. Medical education, UAMS, 1981. Internship/Residency, University of Oklahoma Medical College, Tulsa, 1984. Board certified.

## BATESVILLE

**Angel, Jeff D.**, Orthopaedic Surgery. Born February 3, 1962. Medical education, UAMS, 1988. Internship/Residency, UAMS.

## BENTONVILLE

**Weeden, Daniel S.**, Internal Medicine/Pediatrics. Born February 6, 1963. Medical education, Oklahoma College of Medicine, Oklahoma City, 1989. Internship/Residency, Oklahoma Health Sciences Center, 1993. Board certified.

## BRYANT

**Ulmer, Sue A.**, Internal Medicine. Born December 27, 1956. Medical education, UAMS, 1990. Internship/Residency, UAMS, 1993.

## CONWAY

**Young, Karen L.**, Psychiatry. Medical education, UAMS, 1989. Internship/Residency, UAMS, 1993. Board eligible.

## EL DORADO

**Kamdar, Vikram R.**, Psychiatry. Born August 9, 1950. Medical education, M.P. Shah Medical College, Jamnagar, Gujarat State, India, 1974.

## FAYETTEVILLE

**Hardy, Kyle G.**, Pulmonary/Critical Care. Born March 29, 1960. Medical education, UAMS, 1987. Internship/Residency, UAMS, 1990. Board certified.

**Hurlbut, Kevin M.**, Physical Medicine & Rehabilitation. Born March 31, 1962. Medical education, University of Kansas School of Medicine, Kansas City, Kansas, 1989. Internship/Residency, UAMS, 1993.

**Thomas, Joanna M.**, Family Practice. Born March 27, 1960. Medical education, University of Liverpool School of Medicine, England, 1984.

## FORREST CITY

**Ajamoughli, Ghaith**, Emergency Medicine. Born May 19, 1958. Medical education, University of Damascus College of Medicine, Syria, 1983. Internship/Residency, U.T. - Memphis College of Medicine.

## FORT SMITH

**Edattukaren, Varghese**, Family Practice. Born February 3, 1946. Medical education, Kerala University and T.D. Medical College, Alleppey, India, 1971. Internship, T.D. Medical College Hospital, Alleppey, Kerala, India, 1973. Residency, University of Oklahoma, Tulsa and AHEC Fort Smith, 1993.

**Ivey, Traci L.**, General Medicine. Born August 16, 1960. Medical education, Louisiana State University, Shreveport, 1987. Internship, Louisiana State University Medical Center, 1988.

**Sull, Won J.**, Vascular Surgery, General Surgery & Endoscopy. Born October 6, 1941. Medical education, Seoul National University, Korea, 1966. Internship, Prince George's Hospital, 1967. Residency, Meridian Huron Hospital, 1971.

**Wilson, James C.**, Family Practice. Born December 22, 1951. Medical education, Kirksville College of Osteopathic Medicine, Kirksville, Missouri, 1986. Internship, Kirksville Osteopathic Medical Center, 1987. Residency, UAMS and AHEC Fort Smith, 1993. Board certified.

## HOT SPRINGS

**Bodemann, Donald R.**, Internal Medicine. Born November 28, 1962. Medical education, KU Medical School, Kansas City, Kansas, 1989. Internship/Residency, Duke University, 1992. Board certified.

**Fuerst, Erwin J.**, General Surgery. Born November 13, 1926. Medical education, Bavarian Julius Maximilian University Medical School, Wuerzburg, Germany, 1951. Internship/Residency, University Hospital Wuerzburg 52, Orangeburg Regional Hospital, South Carolina, 1960. Board certified.

**Reinhart, Jeff H.**, Family Practice. Born December 10, 1961. Medical education, UAMS, 1989. Internship/Residency, Pine Bluff AHEC, 1992. Board certified.

**Schauder, Craig S.**, Dermatology. Born December 21, 1960. Medical education, University of Michigan, Ann Arbor, 1987. Internship, University of Alberta, 1988. Residency, University of Texas Medical School, 1991. Board certified.

## JACKSONVILLE

**Bard, John L.**, OBGYN. Born August 29, 1960. Medical education, UAMS, 1987. Internship, New Havana Memorial Hospital, Wilmington, North Carolina, 1988. Residency, Lehigh Valley Hospital, Allentown, Pennsylvania, 1993. Board eligible.

**Johnson, Kelli A.**, Family Practice. Born May 5, 1962. Medical education, UAMS, 1990. Internship/Resi-

dency, AHEC Northwest, Fayetteville, 1993. Board certification pending.

## JONESBORO

**Bertelsen, Richard A.**, Internal Medicine. Born September 15, 1962. Medical education, Bowman Gray School of Medicine, Winston-Salem, North Carolina, 1990. Internship/Residency, UMC, Jacksonville, Florida, 1993.

**Johnson, III, John A.**, General Surgery. Born July 14, 1961. Medical education, University of Mississippi Medical Center, Jackson, 1988. Internship, Bethesda Naval Medical Center, 1989. Residency, University of Mississippi Medical Center, 1993. Board eligible.

## LITTLE ROCK

**Aukstulis, Jim G.**, Child Psychiatry. Born February 1, 1942. Medical education, UAMS, 1987. Internship, UAMS, 1988. Fellowship, Arkansas Children's Hospital, 1992.

**Beverly, Carolyn L.**, Preventive Medicine. Born August 8, 1955. Medical education, University of KS School of Medicine, Kansas City, Missouri, 1981. Internship, Scott AFB, 1982. Residency, University of South Carolina, Columbia, 1990.

**Calkins, Joe B.**, Internal Medicine. Born November 29, 1960. Medical education, UAMS, 1990. Internship/Residency, UAMS, 1990. Board certified.

**Haut, Dawn P.**, General Pediatrics. Born July 2, 1964. Medical education, UTHSCSA, San Antonio, Texas, 1990. Internship/Residency, UAMS, 1993. Board certified.

**Karkos, Jerie B.**, Pediatrics. Born July 25, 1950. Medical education, University of Illinois, Peoria, 1979. Internship/Residency, Southern Illinois University, 1983. Board certified.

**Keller, Kevin R.**, Pediatrics/Allergy and Immunology. Born July 24, 1959. Medical education, University of Texas Medical Branch, Galveston, 1988. Internship/Residency, UAMS, 1991. Board certified.

**Langford, Timothy D.**, Urology. Born October 1, 1960. Medical education, UAMS, 1988. Internship/Residency, UAMS, 1993.

**Marshall, Byrne R.**, OBGYN. Born November 13, 1936. Medical education, University of Michigan, Ann Arbor, 1962. Internship, Wayne County General Hospital, 1963. Residency, University of Michigan Medical Center, 1967. Board certified.

**Rader, George R.**, Anesthesiology. Born September 9, 1961. Medical education, UAMS, 1988. Internship/Residency, UAMS, 1992. Board eligible.

**Schonefeld, Pamela J.**, Internal Medicine. Born October 11, 1965. Medical education, Louisiana State University, New Orleans, 1990. Internship/Residency, UAMS, 1993.

**Ziller, III, Stephen A.**, Gastroenterology. Born July

16, 1962. Medical education, University of Cincinnati Medical School, 1988. Internship/Residency, UAMS 1990. Board certified.

## MOUNTAIN HOME

**Barnes, Gregory F.**, OBGYN. Born July 1, 1963. Medical education, UAMS, 1989. Internship/Residency, University Hospital - UAMS, 1993.

## NEWPORT

**Brown, Randel W.**, Emergency Medicine. Born November 20, 1957. Medical education, UAMS, 1990. Internship/Residency, University Hospital - UAMS 1993.

**Hunt, Randall E.**, Family Medicine. Born October 3, 1952. Medical education, UAMS, 1990. Residency, AHEC Northeast, Jonesboro, 1993.

## NORTH LITTLE ROCK

**Blaisdell, Greg D.**, Psychiatry. Born January 29, 1961. Medical education, University of Texas, San Antonio, 1989. Internship/Residency, UAMS, 1993.

## SILOAM SPRINGS

**Johnson, Steven P.**, General Practice. Born November 27, 1962. Medical education, College of Osteopathic Medicine, Oklahoma State University, Tulsa, 1991. Internship, Dallas/Fort Worth Medical Center, 1992.

## TEXARKANA

**Alston, Thomas J.**, Internal Medicine/Administration - Medical Director. Born September 15, 1937. Medical education, UAMS, 1963. Internship, U.S. Naval Hospital, Portsmouth, Virginia, 1964. Residency, UAMS and Baptist Memorial Hospital, Memphis, 1973. Board certified.

## TRUMANN

**Baker, Kevin G.**, Family Practice. Born September 5, 1962. Medical education, Oklahoma State University - College of Osteopathic Medicine, Tulsa, 1990. Internship, Tulsa Regional Medical Center, 1991. Residency, UAMS AHEC Northwest, 1993.

## WILMOT

**Hicks, Charles E.**, General Practice. Born January 25, 1935. Medical education, UAMS, 1960. Internship, Baptist Medical Center, 1961.

## RESIDENTS

**Alderink, Carlisle J.**, Pathology. Born January 1, 1966. Medical education, UAMS, 1993. Residency, UAMS.

**Bigham, IV, Virgil L.**, Pediatrics. Born November 16, 1965. Medical education, University of Mississippi



Jackson. Internship/Residency, Arkansas Children's Hospital.

**Blakely, Brent M.**, Anesthesiology. Born January 20, 1963. Medical education, UAMS, 1991. Internship/Residency, UAMS.

**David, Alex S.**, Internal Medicine. Born April 9, 1960. Medical education, UAMS, 1990. Internship/Residency, UAMS.

**Flamik, Darren E.**, Emergency Medicine. Born November 30, 1964. Medical education, Texas Tech University HSC, Lubbock, 1993. Internship/Residency, UAMS.

**Griffin, David D.** Born May 24, 1966. Medical education, UAMS, 1993. Internship, University Hospital.

**Hill, Harold R.**, Family Practice. Born December 8, 1966. Medical education, UAMS, 1993. Internship/Residency, AHEC - Pine Bluff.

**Hopkins, John T.**, Pediatrics. Born February 2, 1967. Medical education, University of Missouri, Columbia, 1993. Residency, UAMS - Arkansas Children's Hospital.

**Jamison, Diane E.**, Pediatrics. Born July 22, 1967. Medical education, LSU Medical Center, Shreveport, 1993. Internship/Residency, UAMS.

**Lorio, Allison**, Anesthesia. Born May 3, 1967. Medical education, Louisiana State University, Shreveport. Internship/Residency, UAMS.

**Lorio, D'Ette E.**, Pediatrics. Born September 1, 1966. Medical education, University of Mississippi Medical Center, Jackson, 1993. Internship/Residency, Arkansas Children's Hospital.

**Lorio, Jerry J.**, Orthopaedic Surgery. Born April 15, 1967. Medical education, Louisiana State University, Shreveport, 1993. Internship/Residency, UAMS.

**Miller, Mark E.**, Family Practice. Born June 3, 1967. Medical education, UAMS, 1993. Internship/Residency, UAMS, AHEC Northwest, Fayetteville.

**Mitchell, Rhonda K.**, Family Medicine. Born May 10, 1967. Medical education, UAMS, 1993. Internship/Residency, AHEC - Pine Bluff.

**Shaver, Mary J.**, Internal Medicine. Born June 29, 1966. Medical education, UAMS, 1993. Internship/Residency, UAMS.

**Sherwood, Max A.**, Urology. Born April 27, 1960. Medical education, UAMS, 1993. Internship/Residency, UAMS.

**Stone, Ilya**, Pathology. Born July 3, 1965. Medical education, University of Mississippi, Jackson, 1993. Residency, UAMS.

**Taylor, Toby A.**, MED/PED. Born August 11, 1965. Medical education, UAMS, 1993. Internship/Residency, UAMS.

**Van Hoy, Tess B.** Born September 9, 1967. Medical education, Louisiana State Medical Center, Shreveport. Internship, UAMS.

**Wiggins, Mark W.**, Family Medicine. Born December 9, 1965. Medical education, Mercer University School of Medicine, Macon, Georgia, 1993. Residency, UAMS, AHEC Northwest, Fayetteville.

## STUDENTS

Henry J. Baughman, III

Paul E. Bean

Clay B. Brashears

Mark E. Corbell

Karen L. Cormier

Timothy R. Diles

Donna M. Franz

Janet H. Green

Michael S. Higginbotham

Charles R. Horner, Jr.

Theo N. Hronas

Charles A. Jackson

Spencer A. Land

Lisa A. Lowery

David L. Naylor, Jr.

Manish M. Patel

Juan C. Roman

LaRhonda K. Sims

Rowland T. Stewart

Rick A. Stough

James E. Wood, III

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WORM DRIVE

A-B SWITCH

WEDGE DATA TERMINALS

MULTI-USER ENVIRONMENT

NETWORKING

ACCEPT ASSIGNMENTS

CROSSOVER CLAIMS

CHARGE SLIPS HMO WRITE-OFF

CURRENT PROCEDURAL TERMINOLOGY

OUTSIDE LAB CHARGES

SUPERBILL PPO

WORKMAN'S COMPENSATION

ICD DIAGNOSIS CODES

REFERRING PHYSICIAN SECONDARY

GROUP NUMBER HICFA

PLACE OF SERVICE CODE

PRIOR AUTHORIZATION

TYPE OF SERVICE CODES

SAME/SIMILAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING

ROOM

DISABILITY

APPOINTMENT BOOK

SELF PAYS MEDICAID

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CHARGE SLIPS

PATIENT STATEMENTS

RELATIONSHIP TO THE INSURED

APPROVED AMOUNT

DATE OF DISABILITY

RESPONSIBLE PARTY

PATIENT RECORDS

INDIVIDUAL POLICY NUMBER

WRITE-OFF

MEDICARE

PAYMENT

TYPEWRITER

CODING REQUIREMENTS

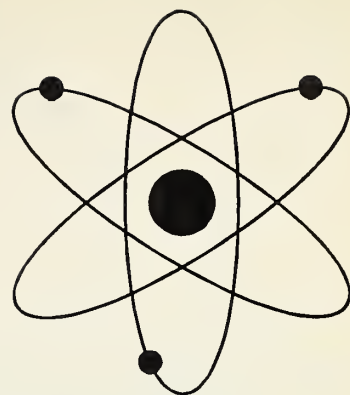
DATE OF DISABILITY

RESPONSIBLE PARTY

INDIVIDUAL POLICY NUMBER



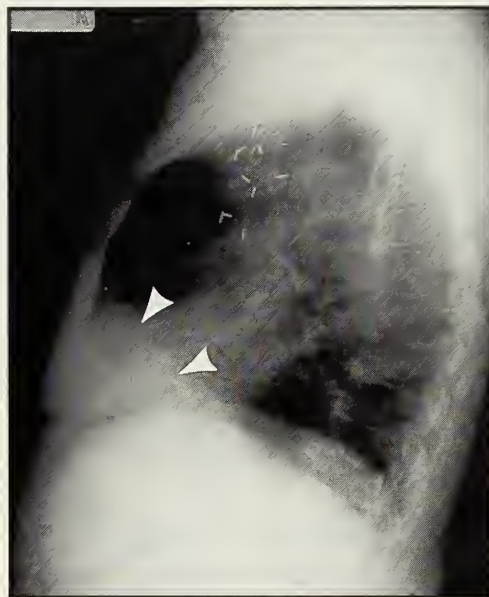
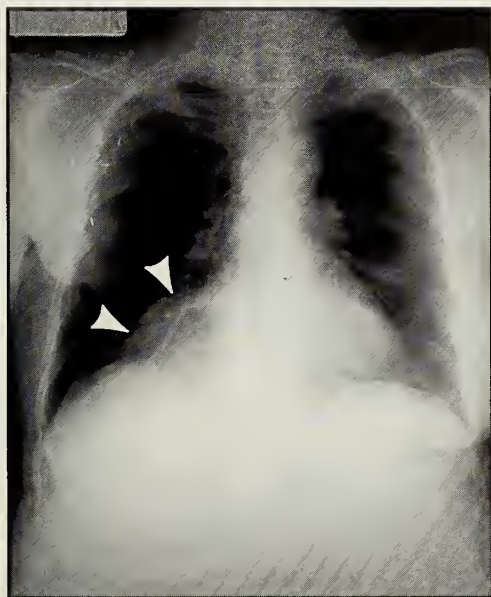
# Radiological Case of the Month



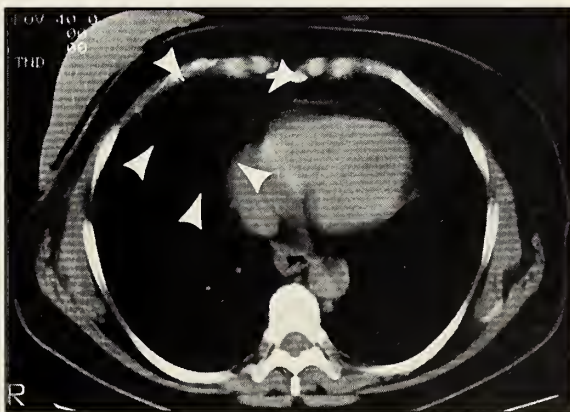
David L. Harshfield, M.D.  
Michael T. Pilcher, M.D.  
Kelly Grigg, B.S.

## History:

Routine CXR in a 57-year-old female with a history of previous breast cancer and modified radical mastectomy 12 years prior to this film.



Above: Figure 1  
Above right: Figure 2  
Right: Figure 3



---

# Normal epicardial fat pad.

---

## Findings:

On the CXR (figures 1 and 2) there is the appearance of a smooth, slightly lobulated mass in the right cardiophrenic sulcus. There are post mastectomy changes (overall decreased density of the right thorax, surgical slips) on the right. The CT (figure 3) reveals the tissue in this region to be fat density, with no presence of a soft tissue mass.

## Discussion:

Epicardial fat pads may be confused with cysts and neoplasm. The fat collections are variable in size and configuration correlating with the patient's body weight. Irregular epicardial fat can be misinterpreted as a tumor and precipitate unnecessary surgery. The fat can extend into the interobar fissures creating an even more confusing appearance.

## Bibliography:

Nahon, J.R.: Roentgen characteristics of the Epicardial fat pad with a case report. Radiology 65:745, 1959.

---

*Editor: Dr. David Harshfield is chief of the radiology service at the Veterans Administration Hospital in Little Rock, and director of radiology at Riverside Radiologist Group in North Little Rock.*

*Contributor: Dr. Michael T. Pilcher is an internal medicine specialist at Arkansas Internal Medicine Clinic in North Little Rock.*

*Contributor: Kelly Grigg is a premedical student research assistant at the University of Arkansas for Medical Sciences in Little Rock.*



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# Resolution

---

## Thomas G. Johnston, M.D.

Whereas, the membership of the Pulaski County Medical Society notes with heart-felt sympathy the recent death of an esteemed member, Thomas G. Johnston, M.D.; and

Whereas, he was a faithful member of this organization for over forty-five years and had given generously of his time and talent to positions of leadership in the medical community; and

Whereas, Dr. Johnston's empathy and concern for his patients was a hallmark of his practice; be it therefore  
*RESOLVED*, that this resolution be adopted and filed in the permanent records of this Society; and  
*RESOLVED*, that a copy be mailed to Dr. Johnston's family as a token of our sincere sorrow; and  
*RESOLVED*, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
May 19, 1993

By Order of the Memorials Committee  
Bruce E. Schratz, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

## Harold D. Langston, M.D.

Whereas, the members of the Pulaski County Medical Society are saddened by the recent death of their esteemed colleague, Harold D. Langston, M.D.; and

Whereas, Dr. Langston was a loyal member of this Society for thirty-three years and was highly respected by its members for the many contributions he made to his chosen field of Radiology; and

Whereas, Dr. Langston's abiding concern for his patients was evidenced by the important role he played in the founding of the Central Arkansas Radiation Therapy Institute; be it therefore

*RESOLVED*, that this resolution be adopted and placed in the permanent archives of this Society; and  
*RESOLVED*, that a copy be forwarded to Dr. Langston's family as an expression of our heart-felt sympathy; and  
*RESOLVED*, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
May 19, 1993

By Order of the Memorials Committee  
Bruce E. Schratz, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

# In Memoriam

---

## Mary Elizabeth Stephenson Archer

Mary Elizabeth Stephenson Archer, of Conway, died Tuesday, May 18, 1993. She was 73.

Survivors are her husband, Dr. Charles A. Archer, Jr.; a son, Charles A. Archer, III of Niles, Michigan; a daughter, Sarah Jane Yoakum of Benton; a sister, Sara Morrow of Austin, Texas; and four grandchildren.



## William Watkins Christeson, M.D.

Dr. William Watkins Christeson, of Little Rock died Friday, June 4, 1993. He was 71.

Survivors are his wife, Bettie Christeson; a son Michael Haynie Christeson of Little Rock; two daughters, Dianne Phillips of Bauxite and Carol Bulloch of Little Rock; two stepchildren, Mel Black Carlson of Dallas and Marcus Black of Loveland, Colorado; and eight grandchildren.



## 10 Arkansas Doctors Visit the White House

Rep. Jay Dickey, R-Ark., led a delegation of Arkansas physicians who met with President Clinton and first lady Hillary Rodham Clinton on Monday, June 7, 1993 at the White House.

The physicians were Charles Davis, Lloyd Langston and James Lindsey, of Pine Bluff, Walter John Giller and Richard Pillsbury, both of El Dorado, J.P. Burge of Lake Village, Kerry Pennington of Warren; Carl Shipp of Texarkana, John Trieschmann of Hot Springs and Ralph Maxwell of Monticello.

Dickey and the physicians had a 30 minute meeting with the first lady in the Roosevelt Room. The group was joined by Lynn Zeno, director of governmental affairs for the Arkansas Medical Society.

About halfway through their meeting, the Arkansas delegation received an unexpected invitation to meet with the president. They moved across the hallway for a 20 minute Oval Office session.

"The purpose of this meeting was to express to the administration what our patients have been telling us," said Dr. Lloyd Langston, according to a quote in the *Arkansas Democrat-Gazette*. "I feel it was a productive discussion."

**Dr. Gene Alexander** of Cooper Clinic recently completed the Family Practice Update sponsored by University of Mississippi Medical Center in Jackson, Mississippi. This course provided 27.0 hours of continuing medical education credits with topics including updates on immunizations, diabetes, antibiotics, asthma, heart disease in women, and congestive heart failure. Dr. Alexander completed in-depth workshops on suturing and joint aspiration and injection.

**Dr. Raymond V. Biondo**, a retired physician of Sherwood, recently received the Boy Scouts of America's National Torch of Gold Award for Exceptional Service to Scouts with Disabilities and The National William H. Spurgeon Award for Distinguished Service to the Explorer Program.

**Dr. Jerry Blaylock**, psychiatrist, was recently appointed to the Governing Board of St. Bernard's Regional Medical Center. He has been a staff member of the medical center since 1973, during which time he served as chief of staff.



The delegation discussed such concerns as whether patients will be allowed to choose their own physicians and what role general practitioners will fill.

"People are concerned and uncertain about what will happen with their health care," Dickey said, according to the *Arkansas Democrat-Gazette*. "This was an opportunity for health-care professionals who work in the field every day to report their views to the administration."

**Dr. Billy E. Greening**, of Pangburn, has been granted membership in the Southern Medical Association. Dr. Greening is affiliated with Central Arkansas Hospital in Searcy, Arkansas.

**Dr. Jeffrey Marvel** of Holt-Krock Clinic Ear, Nose and Throat Clinic has been certified as a Diplomate of the American Board of Otolaryngology.

**Dr. Charles H. Rodgers**, M.D., a family physician in Little Rock, has been appointed to the Committee on Scientific Program of the American Academy of Family Physicians, a national medical organization representing family physicians and medical students.

**Dr. Peter O. Thomas**, Chief of Medical Affairs for Southwest Hospital in Little Rock, was honored at a special birthday celebration for both him and Southwest Hospital on March 2 at the Little Rock Country Club. During the festivities the Governing Board announced the renaming of the Southwest Medical Arts Building to the Peter O. Thomas Medical Arts Building.

## Health Care Access Foundation Update

As of June 1, 1993, the Arkansas Health Care Access Foundation has provided free medical service to 6,000 medically indigent persons, received 6,309 applications, and enrolled 11,874 persons.

The program has 1,605 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

## Dial An Interpreter

Hospitals and doctors offices that have no access to interpreters can call the AT&T Language Line at (800) 752-6096.

This 24-hour phone line provides interpreters in 140 languages, from Azerbaijani to Zambian.

It's expensive, though: \$3.50 a minute for nonsubscribers, and a \$499 one-time charge plus a reduced per-minute rate for subscribers. The latter include many hospitals, HMOs and clinics, as well as police, insurers and rental-car companies.

Also, medical interpretation experts prefer face-to-face translation, saying it is more accurate, but they concede there may be no alternative for patients speaking rare languages.

Based in Monterey, California, the service was founded in 1984, the bought and expanded by AT&T in 1989.

## AETN Focuses on Arkansas Children's Hospital

Thursday, July 15, at 7 p.m., AETN will air "Everyday Miracles", a behind-the-scenes look at professionals and activities at Arkansas Children's Hospital in Little Rock, a national leader among pediatric hospitals, and will provide viewers the opportunity to phone in medical questions to a panel of experts.

In the first hour of this 2-hour presentation, viewers will follow real-life miracle workers through the everyday challenges they face to improve the health of children. New techniques are featured, such as lengthening bones, giving heart and lungs a chance to heal while an ECMO machine oxygenates blood, and state-of-the-art equipment for detecting high blood pressure in children.

The focus is on seven hospital staff members who do extraordinary things to save the lives of children. An evening in the emergency room is shown as well as several stories related by patients and staff members.

Following the documentary, Anne Jansen will moderate on 1-hour live call-in program during which view-

ers may phone in medical questions to a panel of physicians from Arkansas Children's Hospital. Free information about children's health issues will also be mailed to those calling in.

## Free First Time Mammograms Offered

In conjunction with the fifth annual Arkansas Breast Screening Project, sponsored by the American Cancer Society, seven mammography facilities in Arkansas provided free first-time mammograms to women over age 40.

During the project (October, November and December 1992), 4,963 women received the screening, and 2,204 women learned Breast Self-Examination.

Out of the screenings, physicians detected 17 cancers.

Dr James Hagans was the 1992 chairman of the ACS Breast Cancer Task Force.

The project will begin again in October.

## Research Continues for Preventing Chemotherapy-induced Alopecia (Hair Loss)

Although alopecia is not a serious clinical side effect to cancer chemotherapy treatment, it is reported as the single most distressing psychological side effect for patients undergoing chemotherapy according to Ati M. Hussein, M.D., author of the article "Chemotherapy-Induced Alopecia: New Developments" published in the May 1993 issue of Southern Medical Journal. "Fear of hair loss may cause cancer patients to go so far as to refuse treatment," according to Dr. Hussein.

Two methods used to prevent chemotherapy-induced alopecia are the scalp tourniquet and scalp hypothermia. The purpose of both techniques is to temporarily decrease the blood supply to the scalp which limits the amount of drugs reaching and damaging the hair follicle. A scalp tourniquet is a tightly inflated pneumatic tourniquet with the pressure above the systolic arterial pressure which is placed around the scalp at the hairline for 10 minutes before, during and 20 minutes after the infusion. Drawbacks to this technique include headaches and nerve compression. Scalp hypothermia features a variety of cooling systems including the ice turban (crushed ice bandaged to the head), gel packs (molded on wig stands, frozen and applied to scalp), cool caps (coolant in cap is a mixture of ammonium nitrate and water); and a thermocirculator (designed to circulate coolant between two layers of lightweight plastic cap.)



# There's new hope for pain sufferers.



Exciting developments are taking place in the treatment of chronic and disabling pain. The Pain Care Center at Doctors Hospital in Little Rock is an interdisciplinary specialty unit designed to provide the most effective diagnostic and treatment services for:

Low back pain  
Post surgical pain

Myofascial pain syndrome  
Sympathetic maintained pain  
Other chronic pain syndromes

Migraine headache  
Work-related injuries

Patient referrals can be made by the attending physician simply by calling The Pain Care Center. All inquiries regarding our services are welcomed.

**The Pain Care Center at Doctors Hospital**  
**Doctors Building**  
**500 South University, Suite 707**  
**Little Rock, Arkansas 72205**  
**(501) 671-5505**

# Things To Come

## July 21-25

**15th Annual National Lesbian and Gay Health Conference and 11th Annual AIDS/HIV Forum.** Houston, TX. Sponsored by The George Washington University Medical Center Office of Continuing Medical Education. For more information, contact John F. Vargo, George Washington University Medical Center, Office of Continuing Medical Education, (202) 994-4285.

## July 27-August 1

**55th Annual Meeting of the International College of Surgeons-U.S. Section,** held in conjunction with the 33rd North American Federation Congress. Westin Hotel, Seattle, WA. For more information, call (312) 787-6274.

## August 2-4

**Public Relations: Managing Issues & Information in Today's HMO.** Sheraton Grand, San Diego, California. Sponsored by the Group Health Association of America, Inc. For more information, call (202) 778-3230.

## August 22-27

**New Advances in Internal Medicine: Clinical Applications.** Hyatt Regency, Monterey, California. Sponsored by the Office of Continuing Medical Education, UC Davis Medical Center and School of Medicine. 25 hours Category 1 credit offered. For more information, call (916) 734-5390.

## September 10-12

**Frontiers in Endosurgery.** Washington University Medical Center, St. Louis. 18.5 credit hours Category I. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, contact program chairmen, Ralph V. Clayman, M.D. and Elspeth McDougall, M.D., at (314) 362-6893 or (800) 325-9862.

## September 11-14

**The Decade of the Brain: An International Conference.** The Omni-Shoreham, Washington, D.C. 28 Category I credit hours. For more information contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

## September 17-18

**Physician Executive Leadership.** Washington University Medical Center, St. Louis, Missouri. For more information, call (800) 325-9862.

## September 18

**Suicide.** St. Louis, Missouri. For more information, call Continuing Medical Education, Washington University School of Medicine, at (800) 325-9862.

## September 20-22

**Understanding Managed Care: An Introductory Program for New Managers in HMOs.** Loews Santa Monica Beach Hotel, Santa Monica, California. For more information, call (202) 778-3236.

## October 1-3

**International Liver Symposium.** Marriott Crystal Gateway Hotel, Arlington, Virginia. For more information, contact Daniel E. Reichard, George Washington University Medical Center, Office of CME, Washington, DC, (202) 994-4285.

## October 6-14

**Sixth Biennial Allergy Abroad Seminar.** Holland and Belgium. For more information, contact Phillip E. Korenblat, M.D. at Washington University Medical Center in St. Louis, Office of Continuing Medical Education, (314) 362-6893 or (800) 325-9862.

## October 28-31

**87th Annual Scientific Assembly of the Southern Medical Association.** New Orleans, Louisiana. Fee: \$75 member; \$200 non-member. AMA, AAFP, AOA offered - hours to be announced. For more information call SMA Registration Department (205) 945-1840, (800) 423-4992 or FAX (205) 942-0642.

**MISSOURI: GASTROENTEROLOGIST** - Seeking second BC/BE gastroenterologist to join busy, well-established gastroenterology practice in growing, picturesque midwestern town of 10,000 serving an area of 75,000. Located 40 minutes west of St. Louis, Missouri. Office endoscopy facilities available. Affiliation with excellent community hospital with excellent GI laboratory facilities. Interested applicants should send CV to Eugene Tucker, MD, FACG, FACP, 800 East Fifth Street, Suite 212, Washington, MO 63090.



# YOU

## MAKE THE DIFFERENCE!



In Arkansas, hundreds of physicians, pharmacists, dentists, home health agencies, hospitals and public health agencies have joined forces to support the Arkansas Health Care Access Foundation, Inc. (AHCAF). These providers are part of a unique voluntary effort to provide access to quality health care for low-income Arkansans who do not qualify for government assistance, have no form of health insurance and are living at or below the federal poverty level.

**You can help!** Thousands of Arkansans are potentially eligible for this safety net program. Therefore, continued support from all sectors of the health care community is essential if we are to meet the growing demand. Volunteering your services ensures timely medical attention for those in need. **You make a difference!**

Since 1989 AHCAF has reached thousands of people and led, by example, in the quest for broader access to medical care. And with your continued support we will ensure the health and welfare of all Arkansans.

For more  
information  
on how  
you can help,  
call AHCAF at  
(501) 221-3033  
or (800) 950-8233



**Arkansas Health Care  
Access Foundation, Inc.**

# Keeping Up

## **Mental Health Series:**

### **Co-Dependency: Family Needs in Recovery**

*July 21, 12:00 noon-1:00 p.m., Center for Health Education, Dunkerton Room, St. Vincent Infirmary Medical Center.* Sponsored by St. Vincent Infirmary Medical Center in cooperation with RESTORE and presented by Linda H. Fordyce, LCSW. One hour category I credit offered. Lunch provided. No fee, but registration required: 660-2810.

### **46th AAFP Annual Scientific Assembly**

*July 29-August 1, Excelsior Hotel and Statehouse Convention Center, Little Rock.* Sponsored by the Arkansas Academy of Family Physicians. CME credit offered. For more information, call (501) 223-2272.

### **Controversies in Cutaneous Laser Surgery**

*August 12-14, 7:00-8:00 a.m., registration and continental breakfast, Aspen, Colorado.* Sponsored by UAMS College of Medicine and presented by Milton Waner, M.D. Category I credit: 15 hours.

## **Mental Health Series:**

### **Borderline Personality Disorder**

*August 20, 12:00 noon-1:00 p.m., Center for Health Education, Dunkerton Room, St. Vincent Infirmary Medical Center.* Sponsored by St. Vincent Infirmary Medical Center in cooperation with RESTORE and presented by Annette Slater, M.D. One hour Category I credit offered. Lunch provided. No fee, but registration required: 660-2810.

### **Baptist Memorial Medical Center's Summer Seminar**

*August 21, 8:30 a.m.-12:30 p.m., Fairfield Bay Resort & Conference Center.* Category I credit offered: 4 hours. Fee: \$20.

### **Nutrition & Aging IX: Vitamins and Minerals in Health Disease**

*September 29, 8:00-8:30 a.m. registration, Excelsior Hotel, Little Rock.* Sponsored by UAMS College of Medicine and presented by Ronnie Chernoff, Ph.D. and David Lipschitz, M.D., Ph.D. Registration fee: \$165; VA employees: \$75.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **FAYETTEVILLE-VA MEDICAL CENTER**

*Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*Continuing Medical Education Luncheon, August 13, Sept. 10 & 24, 12:30 p.m., AMI Ozark - Quapaw Room*

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium*  
*Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457*  
*Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom*  
*Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium*  
*Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom*  
*Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom*  
*Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom*

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided*  
*Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.*  
*Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served*



*Joint Tumor Conference*, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Hematology-Oncology Conference*, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Cancer Center Team Conference*, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

#### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*Breast Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*GI Conference*, 4th Friday, 11:30 a.m., Conference Room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

#### **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Chest & Problems Case Conference*, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Medicine Conference*, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Surgery Conference*, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Tumor Conference*, 1st Thursday, 12:00 noon, Assembly room. Lunch provided.  
*X-ray Case Conference*, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

#### **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33

*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D109  
*VA GRECC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital  
 Searcy

## **EL DORADO-AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

## **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center



## **FORT SMITH-AHEC**

*Advances in Plastic Surgery*, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Tuesdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

## **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
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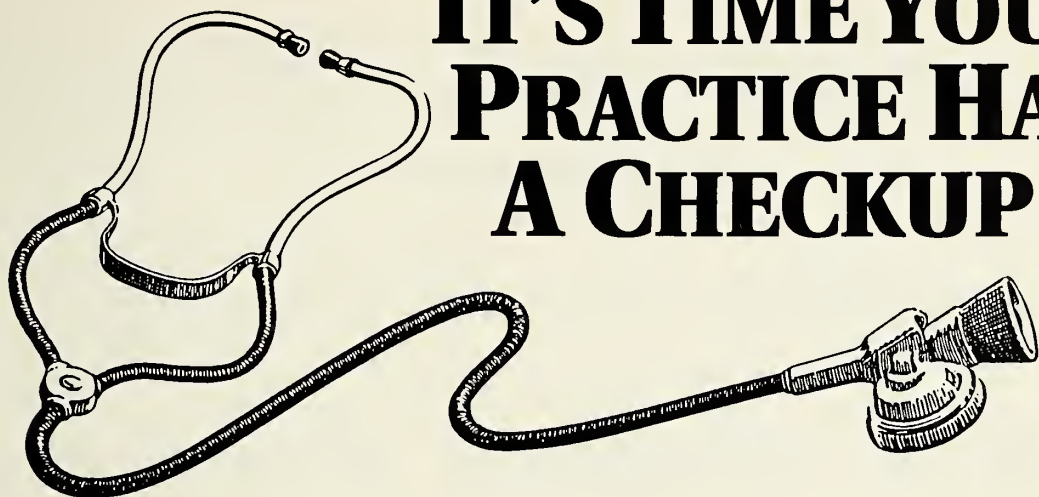
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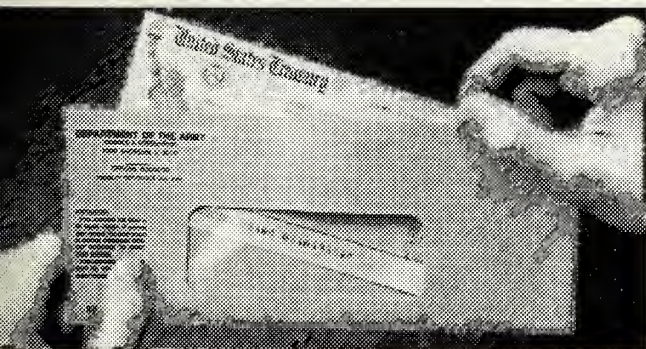
Robert Ranney is the former director of the Department of Practice Management of the American Academy of Family Physicians and has consulted with numerous medical practices to improve the business aspects of their operations. He holds a B.S. in Human Relations from Missouri Valley College and an M.P.A. in Public Administration from the University of Missouri.

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Who Pays for Health Care? <ul style="list-style-type: none"><li>• Government Payers</li></ul>	8:45 a.m. to 10:00 a.m.
Break	10:00 a.m. to 10:15 a.m.
Who Pays for Health Care? (cont'd.) <ul style="list-style-type: none"><li>• Commercial Payers</li><li>• Managed Care</li><li>• Patients and Their Families</li></ul>	10:15 a.m. to 11:15 a.m.
Effective Claims Submissions	11:15 a.m. to 12:00 p.m.
Lunch	12:00 p.m. to 1:00 p.m.
Establishing an Effective Claims System	1:00 p.m. to 1:30 p.m.
Effective Collections	1:30 p.m. to 2:30 p.m.
Break	2:30 p.m. to 2:45 p.m.
Effective Collections (cont'd.) <ul style="list-style-type: none"><li>• Telephone Collections</li><li>• Solutions to Special Problems</li></ul>	2:45 p.m. to 4:00 p.m.
Automating the Claims Submission and Collections System	4:00 p.m. to 4:20 p.m.
Summary and Evaluations	4:20 p.m. to 4:30 p.m.

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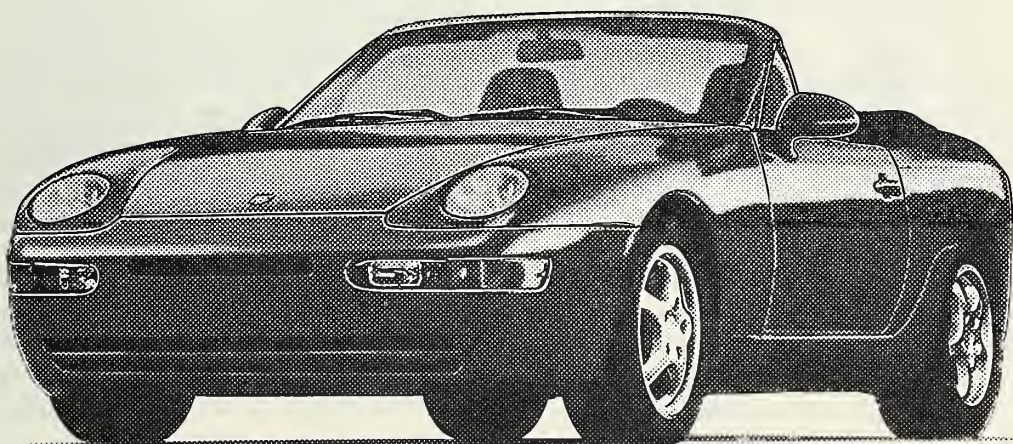
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# Endoscopic Sinus Surgery

## A 300 Case Review

Joe B. Colclasure, M.D.\*

Jeffrey L. Barber, M.D.\*\*

Barbara K. Morris, M.D.\*\*\*

Sharon S. Graham, M.S.\*\*\*\*

### ABSTRACT

The introduction of ESS (endoscopic sinus surgery) has changed and vastly improved the potential of sinus surgery. It is now possible to visualize obstruction in the natural sinus ostia and remove diseased tissue, thereby promoting restoration of normal function. A series of 300 consecutively performed cases is reviewed; results and complications are reported. Findings include a success rate of 94%, with complications in less than 1%. ESS offers a major advancement in treatment of chronic sinusitis.

Sinusitis is one of the most common chronic illnesses in the United States. It has been estimated that 31 million people have had this disease; one person in eight will be affected by sinusitis at some time in his/her life. With the addition of the CT scan and endoscopes, significant improvement in diagnosis and surgical treatment has occurred. With the availability of endoscopic instrumentation, it is not only possible to remove the diseased tissue, but also to promote restoration of normal physiological function.

Endoscopic sinus surgery has gained popularity due to its unique ability to access disease in the ostiomeatal area, which has been difficult if not impossible, to approach by previous methods. Functional endoscopic sinus surgery allows direct visualization of the diseased area with the ability to remove the disease from the involved ostia. Opening the ostiomeatal com-

plex allows the cilia to actively move infection and mucous from the involved sinus into the nose. Previously, before the availability of endoscopic instrumentation, the most common procedure was nasal "windows", which were placed in the inferior meatus. Studies have now conclusively shown that when cilia are functioning normally, the mucous will actively move around the nasal window, not entering the nose as intended by the surgical procedure, and move superiorly and posteriorly to the natural ostia. Functional endoscopic sinus surgery also allows direct visualization of those parts of the ethmoid and sphenoid sinuses involved in the disease process, with removal of the disease from the involved areas. With the aid of the endoscope and a CT scan, the surgical approach to these areas can be carried out more effectively with less risk and morbidity.

As early as 1912, Caldwell<sup>1</sup> suggested the possibility of disease in the ethmoid, sphenoid and frontal sinuses as being implicated in the development of maxillary sinus disease. Later, Hilding, Messerklinger, and Proctor<sup>2</sup> further elucidated findings that the mucociliary transport system motion is superiorly directed toward the natural ostium. Disease free paranasal sinuses necessitate this patent sinus ostium and normal function of the mucociliary apparatus. The susceptibility of other sinuses to ethmoid disease is thought to be related to the structural proximity of the ethmoid to the drainage sites (ostia) of the paranasal sinuses - especially the ostiomeatal complex. This complex consists of a semilunar groove containing the ostia to the maxillary sinus inferiorly and frontal sinus superiorly, bordered posteriorly by the bulging anterior border of the anterior ethmoid sinus (ethmoid bulla) and anteriorly by a ridge of bone known as the uncinate process. Ethmoid cells may also have ostia opening into the semilunar groove. With advent of high resolution CT scan, obstruction and disease in the area of the ostiomeatal complex have now been commonly demonstrated to be

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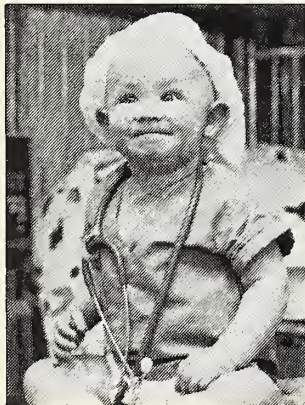


the responsible factor for most chronic sinusitis, which originates in the ethmoid sinus and may lead to involvement in the other paranasal sinuses.

## INDICATIONS AND PREOPERATIVE MANAGEMENT

The primary indication for endoscopic sinus surgery is chronic sinusitis which does not respond to conservative medical therapy. Predisposing causes of sinusitis include: 1) Inflammatory (upper respiratory infection and allergies); 2) mechanical (ostioameatal size and obstruction, septal deformity, polyps); 3) systemic (cystic fibrosis, immotile cilia syndrome, immunodeficiency); and 4) environmental (swimming, diving). Bacteriology of paranasal sinusitis is essentially that of upper respiratory diseases - streptococcus pneumonia, hemophilus influenza, moxarella (Branhamella) catarrhalis, and staphylococcus aureus. Anaerobic organisms and fungi may also be responsible agents. Amoxicillin is frequently cited as the initial drug of choice, with Amoxicillin-clavulanate potassium, cephalosporins, and erythromycin sulfas considered as secondary lines of therapy. Corticosteroid nasal spray is considered an important adjunct. Medical therapy should be continued for a minimum of four to six weeks before a surgical procedure is considered, unless there is evidence of impending complications. Indications other than chronic sinusitis for ESS include obstructive polyps, selected neoplasms, epistaxis, and cerebral spinal fluid rhinorrhea.

A CT scan is essential prior to ESS surgery. While plain sinus films continue to have some place as a screening tool, the number of false negative and false positive films is quite high. A 74% discrepancy rate between CT and plain films has been shown in some studies. Plain sinus films are of little value for definitive evaluation of the paranasal sinuses, with the exception of the maxillary sinuses.



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TABLE I

## CASE SERIES SUCCESS RATES

Follow-Up/ Overall Success	Asymptomatic	Improved	Same	Worse
3 Mos. (88%)	22%	66%	12%	0
6 Mos. (94%)	36%	58%	6%	0
12 Mos. (95%)	45%	50%	5%	0
>2 Yrs.+ (92%)	46%	46%	8%	0

## SURGERY

Endoscopic sinus surgery can be performed under local or general anesthesia. A preoperative coronal CT scan with small cuts is essential to precise evaluation of individual anatomic landmarks. This technique allows removal of disease only in areas evident on visualization, with the guidance of the CT. Endoscopic technique is limited, however, in that it is difficult to operate directly within the frontal sinus and to a lesser extent within the maxillary sinuses, using intranasal technique alone. Significant surgical complications are infrequent. Prevention of such complications requires extensive training in the technique and careful evaluation of any anatomic aberrations on each individual CT scan.

## CASE REVIEW

We reviewed 300 consecutively performed ESS cases. Ages of patients ranged from five years to 82 years. All patients underwent medical management prior to surgery. CT scans were used to monitor disease and for surgical planning. When CT failed to document any improvement following treatment, ESS was considered to be indicated.

Cases in this series were followed from three months to over three years. Of the 300 cases, no patient's symptoms were worse following surgery. As seen in Table I, 88% of the patients followed for three months were either asymptomatic or improved; 94% of those followed six months fell in this category, 95% of those followed 12 months, and 92% of those followed two years or longer. As also demonstrated in Table I, five to 12 percent of the patients were essentially unimproved following surgery.

Three cases (1%) experienced an intraoperative hemorrhage; none required transfusion. One case (0.3%) had a CSF leak which was recognized and repaired at the time of surgery with no long-term sequelae. Eighteen ESS patients (6%) required revision. These findings compare closely to those reported in the literature by



others. Such reports include a 1 to 6 percent incidence rate of hemorrhage; 1 to 3 percent incidence of CSF leak; and rare reports of diplopia, visual loss and death.<sup>1-3</sup> Other complications reported in the literature in 2 to 12 percent of the cases include orbital hematoma, ecchymosis, lacrimal duct injury, synechiae and ostial stenosis.<sup>4</sup> Success rates reported in the literature range from 83 to 96 percent,<sup>5-7</sup> with the need for revision or additional sinus surgery reported in 10 to 23 percent.<sup>8-9</sup>

## CONCLUSIONS

ESS has resulted in the following: 1) dramatically improved diagnostic accuracy with the aid of CT scans; 2) better visualization, improved anatomic knowledge and exposure, resulting in more physiologic surgical approaches; 3) generally less morbidity to patients; 4) improved postoperative results.

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# I Thought I Saw That Report

J. Kelley Avery, M.D.

## CASE REPORT

At age 45, our patient began to experience severe hot flushes associated with sweats, sensation of rapid heartbeat, fluttering in the chest, and so on. The patient stated that these episodes were much more common and much more severe following or during exercise and/or eating.

It was in 1983 that these symptoms began. A routine physical examination was nonrevealing, and laboratory work, including a packed cell volume, white blood cell count, and urinalysis was likewise negative. A Papanicolaou smear showed no significant abnormality.

The diagnosis of menopausal syndrome was made, and the patient was treated with supplemental estrogens.

The patient continued to complain of excessive "menopausal" symptoms, and in 1986 her physician ordered a follicle-stimulating hormone (FSH) assay and a luteinizing hormone (LH) assay; both were found to be within normal limits. Throughout 1986 her symptoms continued, and she also complained of some irregular bleeding. Physical examination again was within normal limits, and the pelvic examination showed no significant abnormality of the uterus or adnexa.

Because of the irregular bleeding which began some three years after onset of the severe menopausal symptoms, a dilatation and curettage (D & C) was done with negative findings, and following the D & C, a CT of the abdomen and pelvis was also done. The report was never seen by the attending physician. We presume that it had been lost in the mail or in his office.

The patient's symptoms continued, and sometimes in the two years following the CT the patient felt a

"knot" in her stomach. At this point, the CT examination of two years before was reviewed. At that time a mass had been present in the liver, and a repeat CT at this time showed a significant growth of the mass.

With respect to the evaluation that followed the D & C, the patient had been informed repeatedly by the physician that "everything was all right." The patient had not specifically inquired as to what the CT showed, but thought that since her physician said "everything was all right" that the CT examination must have shown normal findings. She was not told that the report had been lost.

The patient was admitted to the hospital for elective surgery to biopsy and/or remove the mass in the liver. At surgery, the mass was located without difficulty. It was of tennis ball-size, and was removed without significant difficulty. It had the clinical appearance of a carcinoid tumor, and indeed pathology confirmed that clinical impression.

In the course of the workup that showed that the CT examination two years before had not been taken into account, the patient became angry and filed a lawsuit. In the discovery process, it was apparent that the tumor had grown on CT examination comparing the one two years prior to surgery and the one immediately before surgery.

Although expert testimony was available to discount the importance of the two-year delay as far as definitive surgery was concerned, experts on the other side were willing to say that the patient's prognosis was not as good because of the two-year delay. It proved to be impossible to defend the attending physician, and a large settlement was required.

## LOSS PREVENTION COMMENTS

Some way we must develop systems in our practice that prevent "lost reports." This is a common occurrence regardless of practice discipline. It would seem relatively simple to develop an office system where if a

\* Dr. J. Kelley Avery is chairman of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood, Tennessee, and chief medical officer for ORNDA Health Corporation in Nashville, Tennessee.



report was not returned within a certain period of time, inquiry could be made of the laboratory and/or radiologist as to what the report said. However, the frequency of claims of this type indicates that this must be an exceedingly difficult thing to do.

There are many systems in offices across Tennessee that are designed to prevent this kind of occurrence. In none of the offices where such a system is in place am I aware of a suit like this having occurred. The most frequent system, I believe, is the maintaining of a separate file for the medical record of a patient for whom tests have been ordered or surgery done. This file is not reentered into the routine filing system until all of the reports ordered by the physician are present in the file and have been initialed by him. In other words, if, when our patient had the D & C two years before the definitive surgery and the first CT was done, the patient's file in the physician's office would have remained in the "waiting for report" file until that CT report had been returned. It does complicate the system to some degree when diagnostic tests are done while the patient is in the hospital and the physician is not aware of the report while his patient is hospitalized. However, in almost all of the areas of the state with which I am familiar, an additional copy of the x-ray or laboratory report is sent to the physician's office when a hospital test is done. Since this is true, such a system would protect the physician from an incident of this type.

An additional safeguard is to routinely put all test reports that come to the physician's office on his desk to be read and initialed by him before they are made a part of the file. In our case, there was no report in the office file because, our physician alleged, none had been sent. However, in the development of the case, records were available in the radiologist's office that showed that the report had been dictated and mailed. From previous experience the defense knew that if this case went to court, the attitude of the jury could be negative as far as our doctor was concerned because of the repeatedly stated position that the physician who orders a test is responsible for making sure that the test is done and reported properly. In other words, a layman would ask, "If the test is important enough to order in the first place, doctor, you should make sure that you have the results in hand at an appropriate time!"

The other inescapable finding in this case that made settlement absolutely necessary was that the diagnosis here had been delayed at least two years, delaying definitive treatment by that same period of time. It's very difficult to convince a lay jury that the two years did not make any difference, when one would have to say that had the report been acknowledged two years previously, the surgery would have been done at that time rather than waiting the two years.

Again, look at the systems in your office that could protect you from this kind of lawsuit. Make sure that all reports ordered by you, whether outpatient or in the hospital, become a part of your patient's office record. Assign a responsible employee to the specific task of ensuring that this is done, and, if necessary, develop written protocols as to how this task should be carried out.

All would agree that this should never happen, and yet it very frequently does. ■

*"I never forget  
what it means  
to be a doctor,  
and what it  
means is  
embodied in  
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# The Treatment of Pain in Children

Raeford E. Brown, Jr., M.D.\*

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## ABSTRACT

Pain is an important pediatric health problem. It may have an impact in both the acute and chronic care of children. Safe treatment of both acute and chronic pain in children is possible in the community or hospital setting.

## INTRODUCTION

The treatment of pain is often considered of secondary importance, especially in children. Failure to respond to and treat painful conditions, however, may affect the function of the patient. Postoperative pain may prolong hospitalization, reduce oral intake, and decrease mobility. Chronic limb or back pain, reflex sympathetic dystrophy, or painful neuropathies affect school performance, mood, and family interactions. Lack of treatment may occur because of questions of safety or lack of knowledge regarding the impact of these painful conditions. Pain management is an important aspect of pediatric care that is only now receiving the attention of the medical community. We report here several cases illustrative of our experience at Arkansas Children's Hospital.

## CASE 1

Barry is a twelve-year-old male who suffered a physiofracture of his left leg at age nine. He subsequently developed growth arrest of this leg and leg length discrepancy. An Ilizarov device was placed during a

long operative procedure to help correct this discrepancy. The surgery included an osteotomy of his femur and placement of wires and pins. In order to reduce the intraoperative stress of this procedure and to provide postoperative pain management, an epidural catheter was placed. An infusion of fentanyl and bupivacaine was started in the operating room. This epidural infusion provided Barry with pain control that allowed him to participate in his physical therapy which started the first postoperative day. The infusion was continued for three days postoperatively. Barry's pain was easily controlled subsequent to his epidural infusion with oral analgesics.

## CASE 2

John was diagnosed with acute lymphoid leukemia at age 16 years. He underwent months of chemotherapy hoping to be cured of his disease. Fifteen months after diagnosis, John underwent a bone marrow transplant. His treatment produced severe mouth, esophageal, and abdominal pain. He also had pain from inactivity and from invasive procedures. John's pain was treated with morphine sulfate via a patient controlled analgesia (PCA device). The PCA provided John with a continuous infusion as well as a bolus dose that John could self administer at times when the pain was beyond the control of the infusion. The settings of the PCA were evaluated daily as John's conditioned warranted. John played an active role in his pain management.

Approximately two months after the bone marrow transplant, John began having pain in his ankle and jaw. A bone marrow aspiration revealed that the leukemia had invaded his marrow. John was too weak to undergo further chemotherapy and chose to go home. PCA therapy was continued on an out-patient basis. He or his mother were contacted daily to assess the effectiveness of the PCA. As John became tolerant of the morphine and as the disease progressed, he required frequent increases in his dosage.

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John carried his portable PCA pump with him as he attended high school football games, visited his friends and family, and completed his Christmas shopping. He enjoyed a party in his honor on his eighteenth birthday. John died 62 days after he was discharged from the hospital. His family was grateful that he was able to enjoy his final days.

### CASE 3

Theresa is a thirteen-year-old who has suffered from migraine headaches for eighteen months. Prior to the onset of her headaches, Theresa was very sociable, playing softball and other sports, and she was an honor roll student. Since her headaches have become severe and frequent, she has been placed on homebound tutoring, has been dropped from the softball team, and seldom has friends over. Theresa appears depressed, and her family is very concerned.

She was referred to the Pain Management Clinic at Arkansas Children's Hospital by her local physician. After completing a lengthy questionnaire regarding her pain, she was seen by the multidisciplinary pain team. This team included an anesthesiologist, a nurse practitioner, a pharmacist, a physical therapist, a child life specialist, a social worker, and a psychologist. After her evaluation by each team member, a plan was developed for Theresa's pain management. Two medications were begun that day - amitriptyline, a serotonin modulator to increase her pain threshold, and Inderal, a prophylactic agent used against migraine headaches. A biofeedback program was developed for Theresa in her community to help her identify and control elements that may contribute to her headaches. She was supplied with relaxation tapes that both she and her family enjoyed. Elements of depression and anxiety relating to her health were identified during the evaluation. She was referred to a psychologist in her community for long term personal and family counseling. Her headaches were reduced in intensity and frequency over the next two months and she was able to return to school.

### DISCUSSION

There is substantial evidence to show that development of the physiologic mechanisms and pathways for pain perception take place during late fetal and neonatal life. Pathways necessary for pain perception may be traced from receptors to sensory areas in the cerebral cortex in newborn infants. These pathways are appropriately myelinated and cortical maturation is sufficient to provide for recognition of pain, even in the newborn. Preterm and term newborns respond to noxious stimuli with behavioral and physiological responses suggestive of substantial stress and distress. Physiological consequences of untreated pain may be deleterious to the child, and there are means available to provide analgesia and anesthesia safely to newborns, infants,

children, and adolescents in many if not most circumstances.

Our patient that required the placement of an Ilizarov device for his leg length discrepancy demonstrates a treatment protocol, epidural infusion, which has heretofore been used quite often in adults and has only recently begun to be used routinely in children. This technique provides preemptive analgesia, that is the central nervous system is never made aware of nociceptor signals from the periphery, and therefore, never develops a memory of the stressful event. Current research leads us to believe that those patients that receive preemptive analgesia never develop the levels of pain that patients who have incomplete analgesia suffer. These techniques can be utilized safely in children with appropriately trained nursing and medical staff. Education of the nursing support staff, as well as the availability of practitioners trained in pediatric pain management, are of some importance.

As in the case of acute postoperative pain, children suffer chronic pain, as do adults. Behavioral outbursts, abnormalities in school behavior, or reductions in the psycho-social growth levels of the child may represent manifestations of this pain. Chronic pain in children, whether it be headaches, reflex sympathetic dystrophy, or low back pain requires a multidisciplinary and complete evaluation prior to treatment. There is inevitably an impact on the family and on the personal social situation of the child. We have found the utilization of social workers, psychologists, nurse practitioners, child life specialists, pharmacists, and physical therapists to be of the utmost importance in these cases. If at all possible, attempts are made to use local resources so that children are not forced to travel to centrally located, tertiary care hospitals. With all these children, the emphasis is on increased function and a return to social and psychological normalcy.

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# Doctors Respond with Signs About Medicare Assignment

*The following article was reprinted with permission from Aging Arkansas magazine. The publication has a circulation of 40,000. The voluntary posting agreement was a compromise in exchange for the senior citizens not pursuing a mandatory sign posting law and a law which would prohibit physicians from denying treatment to persons over age 65. Both bills contained significant civil monetary penalties.*

You should be seeing a new sign posted in your doctors' offices. All across the state, physicians are responding favorably to a request from the Arkansas Medical Society (AMS) to post their policy regarding acceptance of Medicare assignment.

Physicians complying with the request are posting signs in a prominent place in reception areas so patients will know the doctor's policy before receiving services. The signs will have one of the following statements: *We Accept Medicare Assignment, We Do Not Accept Medicare Assignment in Some Cases, Please Ask.*

The Holt-Krock Clinic of Fort Smith, a medical services provider with over 100 physicians in satellite offices, has instructed all clinics to post a sign saying they accept Medicare assignment. The signs add the phrase "This information is provided voluntarily by Holt-Krock Clinic through a joint program of the Arkansas Medical Society and Arkansas Senior Citizens."

The signs and the letter from the Medical Society are part of an amicable agreement between the AMS and the coalition that worked on aging legislation during the most recent session of the Arkansas General Assembly.

"With few exceptions, physicians response to the posting of Medicare assignment signs has been very positive," said Lynn Zeno, a spokesman for the AMS. "Small courtesies such as this help improve the doctor-patient relationship."

The initiative for the sign posting began with a bill passed by the 1992 Silver Haired Legislature (SHLS). This SHLS bill was adopted as a legislative priority of the Governor's Advisory Council on Aging (GACA). Members of the SHLS and the GACA joined forces with representatives of other aging organizations to form a legislative task force. Like previous legislative coalitions, the group worked on aging legislation during the 1993 General Assembly.

The Medicare sign posting bill was introduced by Senator Travis Miles of Fort Smith as Senate Bill 603. The AMS offered to ask its membership to post the signs voluntarily. The AMS also suggested forming a special committee of representatives from the medical community and advocates for the elderly. This committee will discuss older Arkansan's health care.

Referring to this committee, Zeno said, "The Medical Society is excited about the second goal of our legislative agreement, the establishment of a senior citizen/physician advisory group. As the Clinton health care reform package unfolds, it will be important for this group to help oversee a smooth transition in light of the proposed monumental changes."

Mary Lou King, special assistant to the director of the Division of Aging and Adult Services, said she was pleased with the voluntary response of Arkansas physicians. "The elderly of Arkansas asked their doctors for these signs and the doctors have responded positively. We're always encouraged when we can work things out without legislation." King added that she hopes this cooperative spirit will continue. "The Arkansas Medical Society has indicated a willingness to work with the elderly of Arkansas. We hope this partnership will allow aging advocates and physicians to address and solve issues of critical importance to both groups."

- by Bean Blencowe and Paul Murray  
Reprinted from July 1993 *Aging Arkansas*

# Despite Intensive Efforts, Egg-Related Salmonellosis Outbreaks Continue

Ned Morton\*

In otherwise healthy individuals, symptoms of *Salmonella enteritidis* (S.e.) infection can be transient. The fever, abdominal cramps and diarrhea may be of such brief duration that an afflicted person does not consult a physician. For the elderly, infants and immunocompromised, however, S.e. infection can be fatal - not only as a result of dehydration associated with diarrhea and vomiting, but also due to a frequent sequela - S.e. septicemia.

The World Health Organization has described S.e. as the cause of an international epidemic. The National Centers for Disease Control/Center for Infectious Diseases states that at least 9,455 illnesses and 46 deaths, attributed to 285 separate outbreaks of S.e. food poisoning, were reported in the U.S. between 1985 and 1990. Many of these occurred in the northeast U.S., but outbreaks have been documented across the country.

Many public health officials believe that the number of incidences reported represent a fraction of actual S.e. cases. For this reason, many public health officials encourage local physicians to consider S.e. infection in differential diagnoses of patients presenting appropriate symptoms. A definitive diagnosis can be made only through isolation and identification of the *S. enteritidis* organism.

When two or more patients are definitively diagnosed at the same time and suspected to be infected from the same food source, public health officials may initiate a trace-back investigation. Outbreaks of S.e. salmonellosis are often associated with improper preparation, handling, storage or presentation of foods.

Frequently, S.e. contaminated table-quality (grade A) shell eggs are implicated in outbreaks. The egg production industry, beleaguered with declining consumption of eggs due to concerns about dietary cholesterol, initiated immediate action when eggs were first

implicated in early cases.

The egg industry aggressively launched a comprehensive program to identify S.e. infected egg-laying flocks. Many of the flocks implicated in those trace-backs were destroyed. Also, eggs from suspected flocks were diverted to industrial food plants for pasteurization. Diversion of eggs to such marketing channels brings substantial economic penalties to producers.

At the urging of the egg production industry, a special task force was formed, supervised by the USDA. The S.e. Task Force conducts trace-backs of human salmonellosis outbreaks to identify S.e. infected egg-laying chicken flocks. The S.e. Task Force is also involved in research to identify causes of S.e. colonization of chickens and to ultimately recommend preventive measures that egg producers might adopt.

In the chicken, S.e. infection usually produces no discernible clinical disease. Health and productivity of the bird is seldom affected or is inapparent. Researchers have determined that the organism may colonize a hen's internal organs and be incorporated in egg contents prior to shell formation.

Feral rodents, particularly mice, which are commonly associated with poultry production houses and their feed distribution systems, are thought to be a reservoir of the pathogens. Control of rodent populations in egg production facilities has been an area of prime emphasis.

Other areas of study have included measures that might prevent S.e. colonization of the hen. This has included vaccination of hens with a *Salmonella enteritidis* bacterin. As part of a total control program, combining intensive sanitation and hygiene practices with vaccination has proven to significantly reduce the risk of S.e. contamination of eggs.

Producers who have been implicated in S.e. trace-backs quite commonly vaccinate new flocks with the bacterin. Those who have not been implicated in S.e. outbreaks, however, are reluctant to adopt vaccination.

\* Ned Morton is a freelance writer from Sioux Falls, South Dakota, who writes about science as well as human and veterinary medicine.



This may be due in part to the social stigma producers associate with the problem as well as the perception that S.e. is a "low risk" problem.

While prophylactic administration of antibiotics through feed and water is a common practice in many areas of food animal production, they are used sparingly in egg production. Nitrofurans, once commonly used to help control coccidiosis and other enteric diseases in poultry and swine, have been withdrawn from over-the-counter markets. Some veterinarians and producers believe the use of nitrofurazone may have helped reduce S.e. colonization and infection of production animals.

Prophylactic use of antibiotics, however, solely to prevent S.e. colonization of the hen, is not economically feasible. Additionally, the practice poses the risk of contaminating human food with drug residues as well as promoting drug resistance in a variety of pathogens common to food animal production.

The development of antibiotic resistant pathogens in animal agriculture is under increasing scrutiny. Many researchers believe that unregulated or poorly coordinated use of antibiotics in food animal production may account for the development of new categories of drug-resistant pathogens. Throughout food animal production, increasing antibiotic resistance among a variety of pathogens has been reported. Many of these pathogens pose risks to human health as well as to the economical production of meat, milk and eggs.

Many antibiotics used in animal production also have therapeutic applications in human medicine. Severe illness may result when some drug-resistant pathogens are encountered by patients on antibiotic regimens prescribed for low-grade infections. Drug-resistant pathogens may flourish in human hosts whose natural intestinal microflora have been debilitated through protracted antibiotic use.

Historically, many physicians have been reluctant to prescribe broad-spectrum antibiotics for patients afflicted with salmonellosis due to the risk of establishing persistently infected carriers of antibiotic-resistant organisms. S.e. infection, however, frequently leading to life-threatening septicemia, may pre-empt such precautions when the elderly, infants or immunocompromised individuals are infected. Prompt initiation of therapy, using

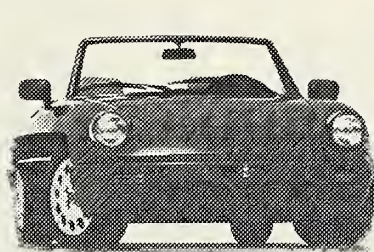
antibiotics to which S.e. have demonstrated sensitivity, should be considered.

As with most salmonella serotypes, *S. enteritidis* is quickly destroyed by common disinfectants and heat as well as a variety of (but by no means, all) antibiotics. At room temperature, *S. enteritidis* can divide every 15 to 30 minutes; sometimes increasing tenfold in an hour. At approximately 45°F, or less, however, the organism stops reproducing. While it may survive freezing and desiccation, sustained temperatures above 120°F (four minutes or more) will kill the organism.

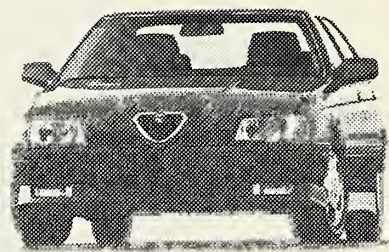
For these reasons, federal and state agencies encourage egg producers, preparers and consumers to

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store and handle eggs appropriately. Consumers are advised to keep eggs refrigerated prior to use and to cook them promptly and thoroughly. Many popular recipes, however, such as Caesar's salad, hollandaise sauce, eggnog and many others require fresh, raw eggs.

Many consumers are unaware of the risk of S.e. contaminated eggs. Others judge the risk to be of such low priority that they do not alter their food preparation and dietary habits. Salmonellosis due to S.e., however, occurs frequently across the country. Several public health officials have encouraged physicians to consider the prevalence of S.e. infection when diagnosing patients that present gastrointestinal disorders symptomatic of S.e. infection.

Additional information on the S.e. epidemic is available from the U.S. General Accounting Office, 202/275-6241 and also from the Division of Bacterial and Mycotic Diseases, Center for Infectious Diseases/Centers for Disease Control, 1600 Clifton Road, Atlanta, GA 30333.

### Facts About S.e. and Eggs

- ✓ At room temperature, S.e. can divide every 15 to 30 minutes; increasing as much as tenfold in an hour.
- ✓ While S.e. may be capable of surviving freezing and desiccation, the organism stops reproducing at temperatures below 45°F.
- ✓ S.e. cannot survive temperatures above 120°F (temperatures normally achieved with thorough cooking).
- ✓ 9,455 illnesses and 46 deaths in the U.S. between 1985 and 1990 were attributed to S.e.
- ✓ The average laying hen produces 250-252 eggs each year.
- ✓ The northeast U.S. (where the majority of S.e. outbreaks have been reported) accounts for approxi-

mately 21% of total U.S. human population and approximately 15% of total U.S. egg production.

### Where Eggs Come From . . .

(Laying hen populations in 30 selected states)

Alabama .....	9,549,000
Arkansas .....	15,977,000
California .....	28,960,000
Colorado .....	3,473,000
Connecticut .....	3,617,000
Florida .....	10,249,000
Georgia .....	17,976,000
Illinois .....	3,178,000
Indiana .....	19,846,000
Iowa .....	9,047,000
Kentucky .....	1,903,000
Louisiana .....	1,135,000
Maine .....	3,956,000
Maryland .....	3,496,000
Michigan .....	5,203,000
Minnesota .....	10,580,000
Mississippi .....	6,167,000
Missouri .....	6,532,000
Nebraska .....	5,680,000
New York .....	3,687,000
North Carolina .....	13,091,000
Ohio .....	17,633,000
Oklahoma .....	3,684,000
Pennsylvania .....	18,934,000
South Carolina .....	5,458,000
South Dakota .....	2,294,000
Texas .....	13,922,000
Virginia .....	3,843,000
Washington .....	4,855,000
Wisconsin .....	3,310,000



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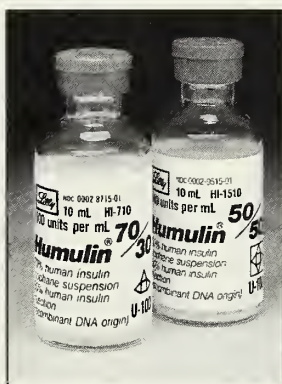





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# American Medical Association Alliance Convention Summary

IT'S OFFICIAL! The AMAA House of Delegates approved the bylaw amendment to change the name of the AMA Auxiliary to AMA Alliance. The tagline, "Physicians' spouses dedicated to the health of America" is used with the official name to better identify the membership and purpose of this organization.

The AMA Auxiliary Convention was held in Chicago, June 13-16. Members of the Arkansas delegation were Sandy Harrison, 1992-93 president; Arleta Power, 1993-94 president; Dr. Paulette Johnson of Hot Springs; Evelyn Thomas of Heber Springs; Peggy Pang of Fayetteville; and Nikki Lawson of Paragould.

In keeping with the national health emphasis of combatting domestic violence we heard two presentations that would peak our concern and educate us to the prevalence of violence around us. One presentation was a very personal and emotional talk by Marilyn Van Derbur, a former Miss America and child abuse survivor. The other presentation was by Dr. Alvin Poussaint, a member of the faculty of Harvard University and advisor for the television "Bill Cosby Show." He spoke on the prevalence of domestic violence in America and its far reaching effects.

Other speakers included: Cokie Roberts of ABC News with an experienced view of what's happening or not happening at the White House; Beverly Sills, general director of the New York City Opera; and a very informative talk by Dr. John Clowe, AMA president;



concerning the type of Health Care System that the AMA feels this country must have to be a long term viable system. The three basic musts are 1) access, 2) quality, and 3) freedom of choice.

The House of Delegates approved a budget of \$1,561,165 for 1993-94. President Gerber presented an AMA-ERF check in the amount of \$2,485,000 to the president of the AMA.

Actions of the House included tabling until 1994 plans to change parliamentary authority to Dr. Davis' Rules of Order; referring to the 1993-94 task force a decision concerning vacancy of nominating committee chairman; referring to By-

law Committee a proposal to change delegate allocation deadlines, defeating a proposal for gender neutral language throughout the AMAA Bylaws, and approval of recognition of states with 75% or more unified members.

On health policy issues, some of the recommendations that passed were that auxiliaries develop and promote programs that address the following problems: member education on breast health; smoking and pregnancy; smoking and teens, particularly women; drinking and driving; alcohol and water sports; head and spinal cord injury prevention; pickup truck passenger safety; bicycle helmet use; fire safety; disaster preparedness; domestic violence statement signatures as a part of marriage license; and medical school training for recognizing domestic violence.



The election of members of the national nominating committee who select the national officers is an important function of the House of Delegates. Those committee members elected for 1993-94 are as follows:

#### ELECTED FROM THE BOARD OF DIRECTORS:

Mollie O. Krafka	South Dakota
Kathy MacKay	Utah
Donna Stone	Nebraska

#### ELECTED FROM THE HOUSE OF DELEGATES:

Anne Youngstrom	Washington
Bobbi Bird	California
Terrie Browning	Kansas
Jean Greco	Pennsylvania
Caramine Holcomb	Virginia

One final note of interest for this year's convention was the presentation of the AMPAC Belle Chenault Award. This award is presented every other year to the AMA Auxilian who has been actively involved in the legislative and political campaigns for the support of medicine. This year's winner was Mrs. Suzie Tonymon (Mrs. Daniel) of Fort Worth, Texas. Mrs. Tonymon is a native of Arkansas and has a son, Ken, who is a practicing physician in Jonesboro and a nephew, Rusty Pang, who is a practicing physician in Fayetteville. Congratulations to her and her supportive family. ■

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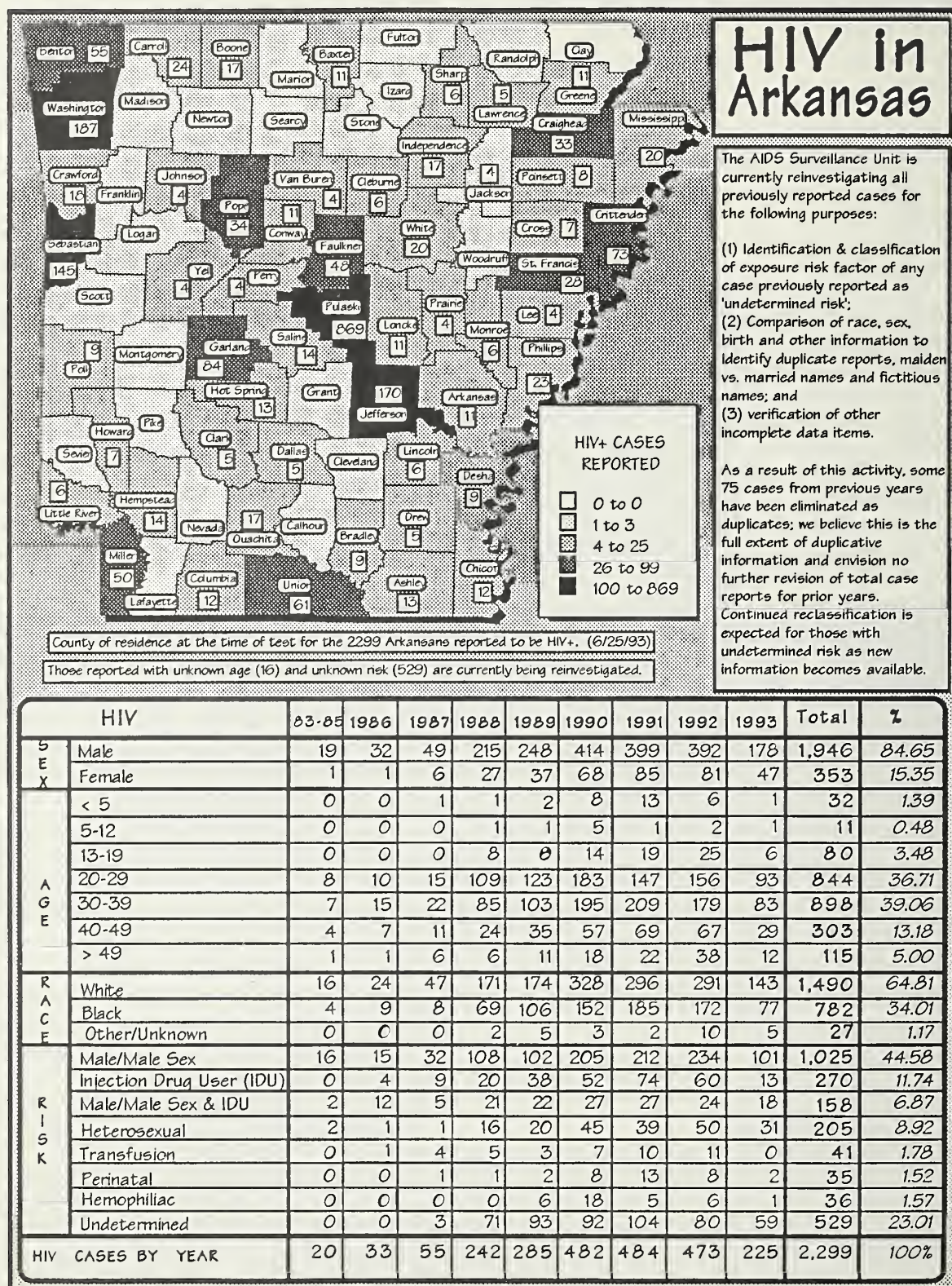
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# Arkansas HIV/AIDS Report 1983-1993

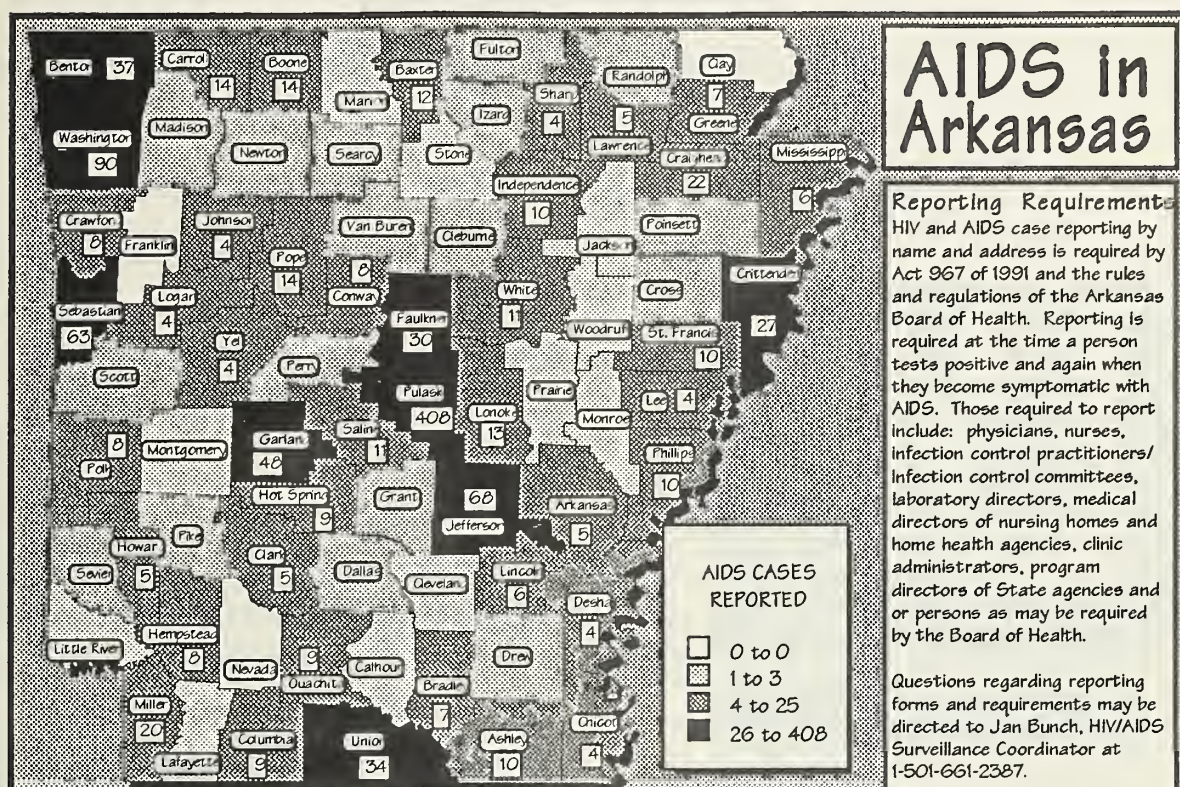


Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1993



Of the 2299 Arkansians reported to be HIV+, 1174 have been diagnosed with AIDS. (6/25/93)

AIDS		83-85	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	202	1,030	87.73
	Female	1	0	4	6	10	20	25	35	43	144	12.27
AGE	< 5	0	0	0	1	1	6	6	3	0	17	1.45
	5-12	0	0	0	1	0	1	1	0	1	4	0.34
	13-19	0	0	0	0	0	4	3	2	4	13	1.11
	20-29	7	9	15	27	24	55	57	81	65	340	28.96
	30-39	3	13	23	36	41	78	80	128	111	513	43.70
	40-49	1	6	8	10	7	35	41	52	48	208	17.72
	> 49	1	0	4	8	7	11	13	19	16	79	6.73
RACE	White	9	22	43	61	58	141	134	207	179	854	72.74
	Black	3	6	7	20	21	47	66	74	62	306	26.06
	Other/Unknown	0	0	0	2	1	2	1	4	4	14	1.19
RISK	Male/Male Sex	7	17	31	59	50	120	120	178	133	710	60.48
	Injection Drug User (IDU)	0	2	10	4	11	18	29	43	34	147	12.52
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	15	96	8.18
	Heterosexual	2	0	2	3	6	10	9	25	27	82	6.98
	Transfusion	0	0	2	7	3	7	11	3	2	35	2.98
	Perinatal	0	0	0	1	1	6	6	3	1	18	1.53
	Hemophiliac	0	0	0	1	1	5	5	4	5	21	1.79
	Undetermined	0	0	1	2	2	6	4	11	28	65	5.54
AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	245	1,174	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.





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# New Members

---

## BATESVILLE

**Neaville, Gregory W.**, Internal Medicine. Born January 2, 1964. Medical education, UAMS, 1990. Internship/Residency, UAMS, 1993.

## FORT SMITH

**Barnes, L. Ford**, Hematology/Oncology. Born August 18, 1943. Medical education, UAMS, 1969. Internship, University of Kansas, 1970. Residency, UAMS, 1974. Board certified.

**Kinard, Hugh C.**, Anesthesiology. Born August 11, 1955. Medical education, Louisiana State University School of Medicine, Shreveport, 1985. Internship, Baptist Memorial Hospital, Memphis, 1986. Residency, University of Tennessee Center for Health Sciences, Memphis, 1989. Board certified.

**McCoy, David M.**, Cardiothoracic Surgery. Born February 11, 1958. Medical education, University of Louisville, Kentucky, 1985. Internship/Residency, University of Florida, 1990; Residency, Medical University of South Carolina, 1993. Board certified.

**Newman, James J.**, Radiology. Born March 16, 1951. Medical education, University of Texas Health Science Center, San Antonio, 1989. Residency, University of Texas Health Science Center, San Antonio, 1993. Board certified.

**Parker, Joel E. Jr.**, Pediatrics. Born April 21, 1938. Medical education, University of Tennessee Medical, Memphis, 1964. Internship/Residency, City of Memphis Hospitals, 1967. Board certified.

**Shahbandar, A. B.**, Internal Medicine/Cardiology. Born November 27, 1956. Medical education, Aleppo University - Faculty of Medicine, Syria, 1980. Residency, Glasgow Royal Infirmary, Scotland, 1988. Internship, Cardey Hospital, Boston, 1993.

## HOT SPRINGS

**Robbins, Mark B.**, Diagnostic Radiology. Born May 4, 1960. Medical education, UAMS 1987. Residency, St Joseph's Hospital, Milwaukee, Wisconsin and UAMS, 1991. Fellowship, 1993. Board certified.

## JONESBORO

**Brannon, Dabney H.**, Primary Care. Born September 5, 1928. Medical education, Medical College of Georgia, Augusta, 1954. Internship, Grady Memorial Hospital, Atlanta, 1955. Residency, Crawford Long Hospital, Atlanta; American Cancer Society Fellowship MD Anderson Hospital, Houston/Preceptor (surgery) VA Hospital, Montgomery, Ala., 1964. Board certified.

**Richards, Fraser M.**, Cardiology. Born June 19, 1953. Medical education, University of Minnesota, Minneapolis, 1980. Internship/Residency, Massachusetts General Hospital, Boston and Duke University Medical Center, 1988. Board certified.

## LITTLE ROCK

**Authement, Chris A.**, Emergency Medicine. Born April 8, 1963. Medical education, LSU Medical College, New Orleans, 1990. Internship/Residency, UAMS, 1993. Board certification pending.

**Brodsky, Michael C.**, Pediatric Ophthalmology & Neuro-ophthalmology. Born March 4, 1955. Medical education, University of Texas School of Medicine, San Antonio, 1981. Internship, Methodist Hospital, Dallas, 1982. Residency, Kresge Eye Institute, Detroit, 1986. Board certified.

**Calderon, Vincent**, Pediatrics. Born April 22, 1960. Medical education, University of Texas Medical Branch, Galveston, 1990. Internship/Residency, Arkansas Children's Hospital, 1993. Board eligible.

**Drew, Mary J.**, Transfusion Medicine. Born September 5, 1957. Medical education, University of Colorado School of Medicine, Denver, 1983. Internship/Residency, University of Colorado Health Science Center, 1988. Board certified.

**Johnston, Kenneth R.**, Family Practice. Born March 16, 1964. Medical education, UAMS, 1990. Internship/Residency, University of Tennessee, Memphis, 1993. Board pending.

**Ma, Frank H.**, Emergency Medicine. Born November 19, 1948. Medical education, UAMS, 1972. Internship, Temple University Hospital, 1973. Residency, UAMS, 1975. Board certified.

**Marshall, James D.**, Critical Care Pediatrics. Born January 31, 1963. Medical education, Tulane University, New Orleans, 1989. Internship/Residency, Stanford University Hospital, 1992. Board certified.

**Powers, Robert E.**, Anesthesiology. Born October 1, 1955. Medical education, University of Mississippi, Jackson, 1981. Internship/Residency, University of Texas Medical Branch, Galveston, 1984. Board eligible.

**Ray, Verna G.**, Emergency Medicine. Born February 13, 1949. Medical education, UAMS, 1977. Internship/Residency, Truman Medical Center and University of Missouri, Kansas City, 1980. Board certified.

**Schonefeld, Michael D.**, Internal Medicine & Nephrology. Born November 16, 1963. Medical education, LSU School of Medicine, New Orleans, 1990. Internship/Residency, UAMS, 1993.

## MOUNTAIN HOME

**Teal, Linda N.**, OB/GYN. Born January 7, 1957. Medical education, UAMS, 1983. Internship/Residency, University Hospital, Little Rock, 1987. Board certified.

## OZARK

**Lachowsky, John L.**, Family Practice/General Medicine. Born January 3, 1949. Medical education, UAMS, 1976. Internship, Bon Secours, 1977. Residency, Medical Center of Central Georgia, 1982. Board certified.

## PINE BLUFF

**Samad, Syed A.**, Gastroenterology. Born April 25, 1958. Medical education, Dow Medical College, Kapachi, Pakistan, 1983. Internship, Marshall University, Huntington, West Virginia, 1990. Residency, University of Texas, Houston, 1991. Board certified.

## RESIDENTS

**Baldwin, Shelly L.** Born September 29, 1967. Medical education, UAMS, 1993.

**Bearden, Jeffrey C.**, Family Practice. Born February 8, 1959. Medical education, UAMS, 1993. Internship/Residency, UAMS/AHEC, Jonesboro.

**Beebe, William E.** Born June 15, 1967. Medical education, LSU Medical Center, Shreveport, 1993. Internship, UAMS, Jonesboro.

**Channell, Daniel B.**, OB/GYN. Born August 6, 1962. Medical education, University of Tennessee, Memphis, 1993. Residency, UAMS.

**Chumley, Willard T. Jr.**, Family Medicine. Born July 2, 1966. Medical education, UAMS, 1993. Internship, AHEC, Pine Bluff.

**Clary, Cathy J.**, Family Practice. Born February 25, 1963. Medical education, UAMS, 1993. Internship, Family Medical Center, AHEC-Northwest, Fayetteville.

**Coleman, Roy D.** Born January 4, 1966. Medical education, UAMS, 1993. Internship/Residency, AHEC, Pine Bluff.

**Contrucci, Ann L.** Born July 7, 1967. Medical education, Medical College of Georgia, Augusta, 1993. Internship, UAMS/Arkansas Children's Hospital.

**Cook, Jonathan M.** Born January 28, 1964. Medical education, West Virginia School of Osteopathic Medicine, 1993. Internship, Jefferson Regional Medical Ctr.

**Dickerson, Brenda K.**, Family Practice. Born June 26, 1963. Medical education, UAMS, 1993. Residency, UAMS.

**Ferguson, Clay W.**, Family Medicine. Born October 6, 1961. Medical education, UAMS, 1993. Internship, UAMS.

**Fort, David Jr.**, Family Practice. Medical education, UAMS, 1993. Residency, AHEC, El Dorado.

**Franks, Hayden H.**, Dermatology. Born March 27, 1967. Medical education, UAMS, 1993. Internship/Residency, UAMS.

**Gannon, Patrick R.** Born July 11, 1966. Medical education, Washington University, St. Louis, 1993. Internship, UAMS.

**Harvey, Jerry L.** Born April 27, 1967. Medical education, Oklahoma State University, College of Osteopathic Medicine, 1993. Internship, AHEC, Pine Bluff.

**Hatfield, Patrick M.**, Dermatology. Born October 22, 1961. Medical education, University of Nevada School of Medicine, Reno, 1993. Internship/Residency, UAMS.

**Henry, William W. Jr.** Born September 8, 1956. Medical education, UAMS, 1993. Internship, AHEC, Pine Bluff.

**Highsmith, William A.**, Family Practice. Born July 24, 1968. Medical education, UAMS, 1993. Residency, AHEC, Pine Bluff.

**Hill, Harold R.** Born December 8, 1966. Medical education, UAMS, 1993. Residency, AHEC, Pine Bluff.

**Kelley, Michael J.**, Med/Pediatrics. Born January 7, 1966. Medical education, University of Louisville, Kentucky, 1993. Residency, UAMS.

**Knowles, Glen C.** Born March 13, 1962. Medical education, OSU COM, 1993. Internship, AHEC, Pine Bluff.

**Krebel, Meredith S.**, Pediatrics. Born August 31, 1961. Medical education, University of Texas Southwestern Med. School, Dallas, 1988. Internship/Residency, UAMS/Arkansas Children's Hospital, 1992. Board certified.

**Laughlin, Catherine L.**, Dermatology. Born July 18, 1967. Medical education, University of Illinois, Peoria, 1993. Internship/Residency, UAMS.

**Maxwell, Teresa M.**, Family Medicine. Born August 16, 1954. Medical education, UAMS, 1993. Internship, UAMS.

**McAtee, James R.** Born May 30, 1967. Medical education, University of Kansas, Kansas City, 1993. Internship, UAMS.

**McCaslin, Debra S.**, Pediatrics. Born September 28, 1967. Medical education, University of Nebraska Medical Center, Omaha, 1993. Residency, UAMS.

**McCaslin, Joseph T.**, Emergency Medicine. Born June 2, 1965. Medical education, University of Nebraska Medical Center, Omaha, 1993. Residency, UAMS.

**Miller, Mark E.**, Family Practice. Born June 3, 1967. Medical education, UAMS, 1993. Internship, Family Medical Center, AHEC-Northwest, Fayetteville.

**Mitchell, Rhonda K.**, Family Practice. Born May 10, 1967. Medical education, UAMS, 1993. Internship, AHEC, Pine Bluff.



**Nighorn, Laura H.**, Family Practice. Born January 1967. Medical education, Texas A & M University Health Science Center, College Station and Temple, Texas, 1993. Internship, Family Medical Center, AHEC-Northwest, Fayetteville.

**Rakhmanina, Natella**, Pediatrics. Born August 17, 1964. Medical education, People's Friendship University, Moscow, Russia, 1988. Internship, People's Friendship University, Moscow, Russia. Residency, UAMS.

**Robinson, Pamela B.**, Ophthalmology. Born December 29, 1967. Medical education, University of Texas ISC, San Antonio, 1993. Internship/Residency, UAMS.

**Smith, Vestal B. Jr.**, Physical Medicine. Born November 27, 1961. Medical education, UAMS, 1990. Internship/Residency, UAMS.

**Stock, Vance B.**, Family Practice. Born July 18, 1964. Medical education, Loma Linda University, Loma Linda, California, 1993. Internship, AHEC-Northwest, Fayetteville.

**Walker, Barry A.**, Family Practice. Born January 1, 1964. Medical education, UAMS, 1993. Internship/Residency, AHEC, Fort Smith.

**Walter, Matthew T.** Born October 30, 1964. Medical education, UAMS, 1993. Internship, Family Medical Center, AHEC-Northwest, Fayetteville.

**Wiggins, Mark W.**, Family Practice. Born December 9, 1965. Medical education, Mercer University School of Medicine, Macon, Georgia, 1993. Internship, Family Medical Center, AHEC-Northwest, Fayetteville.

**Wright, John W.**, Surgery. Born July 5, 1955. Medical education, UAMS, 1990. Internship, St. Louis Hospital. Residency, UAMS.

**Yeager-Bock, Angy M.**, Family Medicine. Born October 9, 1952. Medical education, UAMS, 1993. Internship, UAMS.

## STUDENTS

Julie Cole  
Kevin Diamond  
Raymond W. Edwards  
Tijuana Freeman  
Nicole Miller  
Robert Page  
Rebecca Phillips  
Praba Reddy  
Matthew W. Smith  
Sherri Smith  
Gregory V. Whorton

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CROSSOVER CLAIM EDS

CHARGE SLIPS HMO WRITE-OFF

CURRENT PROCEDURAL TERMINOLOGY

OUTSIDE LAB CHARGES

SUPERBILL PPO

WORKMAN'S COMP

ICD DIAGNOSIS CODES

REFERRING PHYSICIAN SECONDARY

GROUP NUMBER HICFA

PLACE OF SERVICE CODE

PRIMARY CARRIER

PRIOR AUTHORIZATION

TYPE OF SERVICE CODES

SAME/SIMILIAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING LEDGER CARDS WRITE-OFF PARTICIPATING PHYSICIAN

ROOM INSURANCE CARDS GROUP PLOICY NUMBER CHARGE SLIPS MEDICARE

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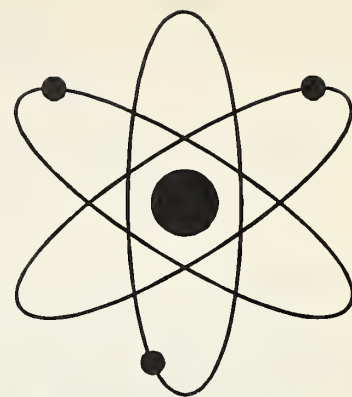
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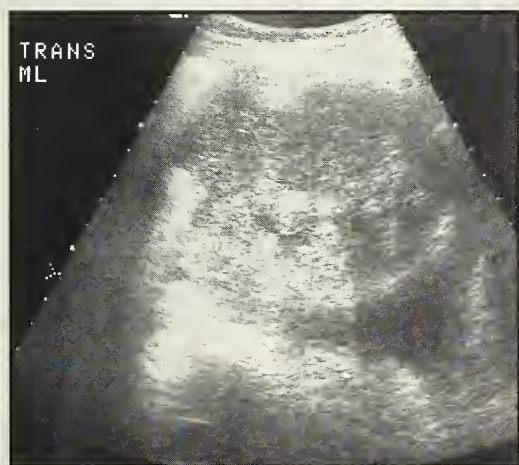
# Radiological Case of the Month



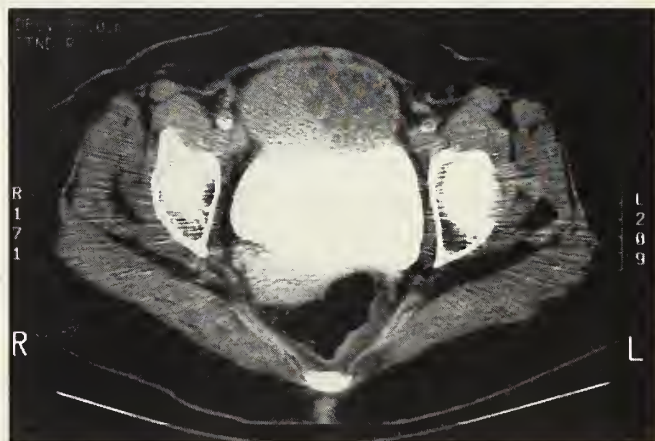
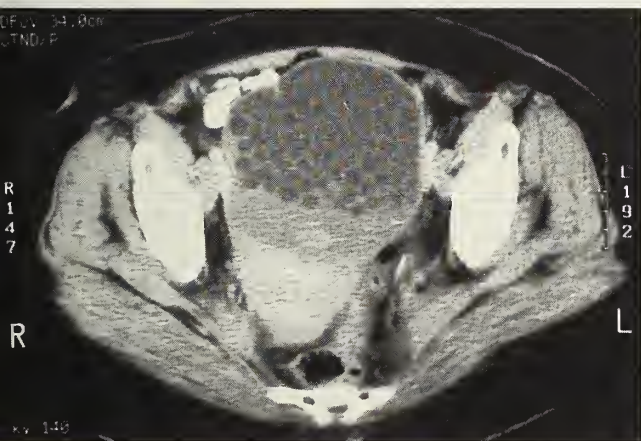
Steven R. Nokes, M.D.  
James A. McMillan, M.D.  
James D. Studdard, M.D.  
W. Everett Tucker, M.D.

## History:

This 65-year-old woman presented with a pelvic mass. An ultrasound (Figure 1) and CT scan (Figures 2 and 3) were performed.



*Figure 1 (left): Transverse pelvic ultrasound.  
Figure 2 (below left): CT scan of the pelvis.  
Figure 3 (below right): CT scan of the pelvis after filling  
the bladder with contrast. The patient had been placed  
in the right lateral decubitus position for ten minutes  
prior to this image.*



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# Dermoid Cyst.

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## Findings:

Ultrasound reveals a large pelvic mass with multiple echogenic foci with some shadowing obscuring a portion of the posterior wall. CT demonstrates a 10 cm mass with multiple nodular lesions. Figure 3 separates the mass from the uterus and shows that the nodular lesions (hair) layer in a gravity dependent fashion.

## Discussion:

Ovarian cystic teratomas (dermoid cysts) are congenital tumors arising from pluripotential germ cells. They comprise 10-15% of ovarian neoplasms and 10-15% are bilateral. Ectodermal elements predominate and they are almost always benign. They occur at any age, as opposed to epithelial tumors which are more common in the active reproductive years.

These tumors have a variable sonographic appearance, depending on their composition. A predominantly cystic mass with an echogenic mural nodule, the "dermoid plug", is considered specific. The dermoid plug contains hair, teeth, or fat and casts an acoustic shadow. The cystic component is often sebum which is liquid at body temperature. A mixture of matted hair and sebum is echogenic due to the multiple interfaces and produces shadowing which may obscure the posterior wall of the mass. This has been called the "tip of the iceberg" sign. A fat-fluid or hair-fluid level (as in our case) is considered specific on CT.

## References:

1. Sheth S, Fishman EK, Buck JL, Hamper UM, Sanders RC. The variable sonographic appearances of ovarian teratomas: correlation with CT. *AJR* 1988; 151:331-334.
2. Skaane P, Huebener KH. Computed tomography of ovarian teratomas with gravity dependent layering. *J. Comput Assist Tomogr* 1983; 7:837-841.
3. Quinn SF, Erickson S, Black WC. Cystic ovarian teratomas: the sonographic appearance of the dermoid plug. *Radiology* 1985; 155:477-478.
4. Guttman PH. In search of the elusive benign cystic ovarian teratoma. Application of the ultrasound "tip of the iceberg" sign. *JCU* 1977; 5:403-406.

---

*Editor: Steven R. Nokes, M.D., is affiliated with Radiology Consultants in Little Rock.*

*Contributor: James McMillan, M.D., is affiliated with Little Rock Medicine Associates in Little Rock.*

*Contributor: James D. Studdard, M.D., is a private practice obstetrician/gynecologist in Little Rock.*

*Contributor: W. Everett Tucker, M.D., is affiliated with the Surgical Clinic in Little Rock.*

*Acknowledgement: We would like to thank Dorothy Staggs for preparing the manuscript.*







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**ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.**

**Dr. Kevin Beavers**, who practices internal medicine in Russellville, was recently honored with the status of Fellow in the American College of Physicians.

**Dr. Carlton Chambers**, Harrison, recently attended two continuing medical education courses at the Manhattan Eye, Ear & Throat Hospital in New York, NY. The courses were "Functional Endoscopic Sinus Surgery" and "Advanced Endoscopic Sinus Surgery."

**Dr. Randy Cole**, an ophthalmologist in Rogers, recently presented his statistical findings at the national American Society of Cataract and Refractive Surgeons meeting in Seattle. He spoke at the Keratorefractive Concepts and Transitions Session, a Systematic Approach to Emmetropia Free Paper Symposium.

**Dr. Morriss Henry**, of Henry Eye Clinic, Springdale, presented his method of no stitch phacofracture cataract surgery at a meeting of ophthalmologists held at UAMS, Department of Ophthalmology, recently.

**Dr. Randy A Jordan**, a cardiologist in the Clinic for Cardiovascular Disease in Little Rock, was elected president of the Arkansas Affiliate of the American Heart Association at the 43rd Annual Delegate Assembly held recently in Little Rock. **Dr. Robert White**, a Paragould Family Practitioner, will serve as vice president.

**Dr. Frederick E. Joyce**, a Texarkana pathologist, has been named the 1993-94 president of the Arkansas Caduceus Club. He is also president of Chappell-Joyce Pathology Association and of Doctors Diagnostic Laboratory.

**Dr. Suzanne Klimberg**, chief of Breast Service at UAMS and chief of Women's Oncology at John L. McClellan Memorial Veterans Medical Center, and **Dr. Scott Stern**, assistant professor in the Department of Head and Neck Oncology at UAMS and director of the Division of Head and Neck Surgery, have both been awarded a Clinical Oncology Career Development Award from the American Cancer Society's National Professional Development Program.

**Dr. Thomas E. Knox**, orthopaedic surgeon in Mountain Home, recently attended the American Academy of Orthopaedic Surgeons' seminar "Sports Injuries of the Foot and Ankle" in Houston, Texas. He also attended the four-day seminar "Comprehensive Trauma Solutions" in Beaver Creek, Colorado.

**Dr. Marvin Leibovich**, medical director of emergency/trauma department and MED-FLIGHT program associated with Baptist Medical Center in Little Rock, recently received the Council Meritorious Service Award from the American College of Emergency Physicians.

**Dr. Sandra Denise Bruce Nichols**, a general practitioner at the Holly Grove Medical Clinic in Monroe County, was appointed to a seat on the state Pollution Control and Ecology Commission. She has also been named to the 33-member Health Care Reform Task Force, created by Governor Jim Guy Tucker.

**Dr. M. Bruce Sanderson**, chairman of the board of trustees at Doctors Hospital in Little Rock, will lead a group of Little Rock physicians and ministers on a trip, dubbed the "Mission of Mercy," to Novosibirsk in Siberia on August 13-21. The group will help supply the Russians with needed medical equipment and information. **Dr. Wanda Stephens**, president of Living Hope Institute at Doctors, is project leader for the mental health team.

**Dr. James Suen**, chairman of the department of otolaryngology at University Hospital in Little Rock, has been named president of the American Society of Head and Neck Surgeons.

**Dr. Terry Yamauchi**, professor and vice chairman at Arkansas Children's Hospital, was one of four White House delegates asked to represent the United States at the World Health assembly in Geneva, Switzerland, recently.

## In Memoriam

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### **Earnest Lee Saunders, M.D.**

Dr. Earnest Lee Saunders, of Jonesboro, died Saturday, July 3, 1993. He was 39.

Survivors are his wife, LaQuita Kenner Saunders, three sons, Charles Saunders, Eric Saunders and Sear Saunders; a daughter, Alexandria Saunders; his parents, Robert and Helen Smith Saunders of Jonesboro; one brother, Robert Saunders, Jr. of Lepanto; and two sisters, Jeanine Saunders of Jonesboro and Dr. Marolyn Speer of Stuttgart.



## **Arkansas Native Provides AIDS Information on Compact Discs**

Dr. Edwin Bymun, a native of Warren, has established Bymun Associates in Oakland, California, that allows doctors to get the latest information on AIDS.

Since 1981, when the first cases of Acquired Immuno-deficiency Syndrome were reported, more than 50,000 articles have appeared in worldwide medical journals. To provide prompt access to this wealth of literature, Bymun Associates created AIDSSCAN CD-ROM - a full-age image digitization of journal articles, which are indexed for easy retrieval.

Physicians, AIDS researchers and other health workers who are now constantly sifting through numerous published pieces of information may find this new method very convenient. AIDSSCAN delivers this much needed information in a very portable and cost efficient manner. CD-ROM is a personal computer based mass storage device that can hold 680 megabytes of information - the equivalent of 275,000 pages of text - and enables users to quickly locate specific information far better than microfiche or expensive on-line mainframe systems. Early shipment of the disc has been to the Center for Disease & Control, National AIDS Hotline, U.S. Surgeon General's Office and the World Health Organization's global AIDS project.

For more information on AIDSSCAN, contact Bymun Associates/ AIDSSCAN, P.O. Box 28691, Oakland, California 94604 or Fax & Voice Mail (510) 839-9273.

## **Lack of Tumor Registry Costs Arkansas Millions**

Arkansas recently received a \$250,000 federal grant to plan for control of breast and cervical cancer, said Dr. David Bourne, a physician at the state Department of Health.

Unfortunately, Arkansas lost out on \$3 million in funding for the same program because the state has no tumor registry.

The federal Centers for Disease Control and Prevention in Atlanta gave \$3 million to each of 12 states in a \$70 million national program to control breast and cervical cancer, Bourne said.

Arkansas was able to get only a smaller grant under a second tier of funding because of the lack of a tumor registry.

Arkansas once had one of the best tumor registries in the United States. The Arkansas State Cancer Commission was a nationally recognized program that gained

the praise of the American College of Surgeons and provided a model for other states' tumor registries.

The program began in the last 1930s when Arkansas doctors opened seven "tumor clinics" for early diagnosis, treatment and follow-up care for indigent patients.

The program included a cancer registry that gathered information from tumor clinics at Texarkana, Pine Bluff, Fort Smith, Jonesboro, El Dorado and two at Little Rock.

Doctors donated their time, and the registry functioned independently until 1971, when it was placed under the state Health Department. It was killed during President Clinton's first term as governor, when it received no funding.

Now, the Arkansas Cancer Control Coalition must build another tumor registry for the state.

The coalition will also develop policies for the prevention, treatment and control of cancer and advocate for those policies.

## **AHEC El Dorado Moving to New Facility**

The Area Health Education Center of South Arkansas will soon be moving to a bigger and better facility.

A fund-raising campaign and plans for a new facility are now in the works, according to Dr. Peter J. Carroll, AHEC director.

Representatives of AHEC, Medical Center of South Arkansas and the University of Arkansas for Medical Sciences in Little Rock recently met with business leaders from the South Arkansas area to discuss the need for the new building.

AHEC of South Arkansas, as well as the other AHECs in the state, have increased their number of resident physicians and expanded programs to the point where larger, more up-to-date facilities are a necessity.

The MCSA Foundation has committed to help raise the projected \$2.5 million for the AHEC facility.

The new building will have about 24,000 square feet and will house administrative offices, an extensive medical library, an interactive video link to UAMS, a large conference area and the clinic.

There are also plans for an "after hours" clinic which will help MCSA by easing the current burden of the hospital emergency room. Also the close proximity to MCSA will give health professionals easier access to the video link, conference center and library.

# Things To Come

## September 10-12

**Frontiers in Endosurgery.** Washington University Medical Center, St. Louis. 18.5 credit hours Category I. Sponsored by the Office of CME, Washington University School of Medicine. For more information, contact program chairmen, Ralph V. Clayman, M.D. and Elspeth McDougall, M.D., at (314) 362-6893 or (800) 325-9862.

## September 11-14

**The Decade of the Brain: An International Conference.** The Omni-Shoreham, Washington, D.C. 28 Category I credit hours. For more information contact John F. Vargo, George Washington University Medical Center, Office of CME, (202) 994-4285.

## September 17-18

**Physician Executive Leadership.** Washington University Medical Center, St. Louis, Missouri. For more information, call (800) 325-9862.

## September 18

**Suicide and Clinical Practice: An Update for Healthcare Professionals.** Doubletree Conference Center, Chesterfield, Missouri. For more information, call Continuing Medical Education, Washington University School of Medicine, at (800) 325-9862.

## September 20-22

**Understanding Managed Care: An Introductory Program for New Managers in HMOs.** Loews Santa Monica Beach Hotel, Santa Monica, California. For more information, call (202) 778-3236.

## September 22-26

**The Practice Management Institute at Lake Tahoe 1993.** Granlibakken Resort, Lake Tahoe. For more information, call the Palmer Associates, (800) 726-1308.

## September 23

**Frontiers in Ovulation Induction.** Marina Del Rey, California. For more information, call the Office of CME, Washington University School of Medicine, at (800) 325-9862.

## October 1

**Recertification: New Evaluation Methods and Implementation Strategies.** Chicago Marriott Hotel O'Hare, Chicago, Illinois. Registration fee: \$235. For more information, call (708) 491-9091.

## October 1-2

**Physician Executive Leadership.** Washington University Medical Center, St. Louis, Missouri. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

## October 1-3

**International Liver Symposium.** Marriott Crystal Gateway Hotel, Arlington, Virginia. For more information, contact Daniel E. Reichard, George Washington University Medical Center, Office of CME, Washington, DC, (202) 994-4285.

## October 2-3

**Ultrasound Update: 1993.** Red Lion Inn, Sacramento, California. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Category I credit: 10 hours. For more information, call (916) 734-5390.

## October 6-14

**Sixth Biennial Allergy Abroad Seminar.** Holland and Belgium. For more information, contact Phillip E. Korenblat, M.D. at Washington University Medical Center in St. Louis, Office of Continuing Medical Education, (314) 362-6893 or (800) 325-9862.

## October 15-20

**1993 Utilization Management Conference/1993 Annual Managed Care Conference & Exhibition.** Disney's Contemporary Resort, Orlando, Florida. Sponsored by the American Managed Care and Review Association. For more information, call (202) 728-0506.

**MISSOURI: GASTROENTEROLOGIST** - Seeking second BC/BE gastroenterologist to join busy, well-established gastroenterology practice in growing, picturesque midwestern town of 10,000 serving an area of 75,000. Located 40 minutes west of St. Louis, Missouri. Office endoscopy facilities available. Affiliation with excellent community hospital with excellent GI laboratory facilities. Interested applicants should send CV to Eugene Tucker, MD, FACP, 800 East Fifth Street, Suite 212, Washington, MO 63090.



### October 21-22

**Managed Care in the 90s.** Hyatt Newporter, Newport Beach, California. Presented by the National Association of Managed Care Physicians. An interactive forum on all aspects of managed care. For more information, call Laura Russell, (800) 722-0376.

### October 21-23

**Traumatic Brain Injury: 1993.** Hilton Inn, Sacramento, California. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Tuition: \$475, physicians; \$375, others. Category I credit: 22 hours. For more information, call (916) 734-5390.

### October 27-28

**How to Plan and Implement a Total Quality Improvement Program for Your Hospital: The Tested 7-Step TQI System to Achieve Quantum Leaps in Efficiency, Speed and Quality.** Ritz Carlton, Houston. For more information, call QualityAlert Institute, at (800) 221-2114.

### October 28-31

**87th Annual Scientific Assembly of the Southern Medical Association.** New Orleans, Louisiana. Fee: \$75 member; \$200 non-member. AMA, AAFP, AOA offered - hours to be announced. For more information, call SMA Registration Department (205) 945-1840, (800) 423-4992 or FAX (205) 942-0642.

### October 29

**Frontiers in Ovulation Induction.** Teaneck, New Jersey. Sponsored by the Office of CME, Washington University School of Medicine. For more information, call (800) 325-9862.

### November 3

**4th Annual Rush Symposium on Transplantation.** Rush-Presbyterian-St. Luke's Medical Center. Fee: \$100 and \$75 for fellows and post-doctoral students. For more information, call (312) 942-6242.

### November 4-7

**12th Annual Scientific Meeting of the American Pain Society.** Buena Vista Palace, Orlando, Florida. For further information, contact Cynthia Porter at The American Pain Society, (708) 966-5595.

### November 5-7

**Fifth Annual Infectious Disease Review Course for the Practicing Physician.** Hyatt Regency Bethesda, Maryland. Sponsored by the Center for Bio-Medical Communication. Category I credit: 17.5 hours. For more information, call (201) 385-8080 or (800) 231-0389.

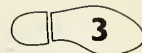
### November 12-14

**Anesthesiology Update: 1993.** Monterey Plaza Hotel, Monterey, California. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine and Medical Center. Category I credit: 14 hours. For more information, call (916) 734-5390.

### November 14-18

**97th Annual Meeting of The American Academy of Ophthalmology.** McCormick Place, Chicago. For more information, call The American Academy of Ophthalmology Meeting Department at (415) 561-8500.

Volume 90, Number 3 - August 1993



Leading is easy  
when you know the  
right steps.



## Interactions

### Medical Staff

### Leadership Conference on Managing Change

October 1-3, 1993 Naples, Florida

We can't dance around the issue any longer. Health system reform is occurring at a fast pace. And it's going to take some fancy footwork for physicians to maintain autonomy and control within their practices.



Master the moves that will help you excel in this environment by attending the fourth annual Interactions Medical Staff Leadership Conference: Managing Change. Sponsored by the American Medical Association (AMA), in cooperation with the Medical Association of Georgia and the Florida Medical Association, this comprehensive three-day conference is designed specifically for new and experienced medical staff leaders.

Physician leaders will benefit by:

- Learning how to hone their leadership skills
- Gaining a greater understanding of health policy and medical practice issues
- Acquiring the knowledge and tools to deal with the changes surrounding health system reform

So lead, don't follow. It's easy, when you know the right steps.

For more information or to register, call

800 621-8335 now!



American Medical Association

Physicians dedicated to the health of America



# Keeping Up

## Update in Primary Care Geriatrics - 3 Part Series

September 11, October 30 & November 13, Baker Conference Center, Washington Regional Medical Center. This conference, sponsored by Washington Regional Medical Center, will be divided into 3 sessions to be held on the Saturday of each Razorback football home game in Fayetteville. Continental breakfast will be served. Fee: \$15. R.S.V.P. by calling the continuing medical education department at 442-1823. Category I credit: 2 hours per session.

## Mental Health Series:

### Borderline Personality Disorder

August 20, 12:00 noon-1:00 p.m., Center for Health Education, Dunkerton Room, St. Vincent Infirmary Medical Center. Sponsored by St. Vincent Infirmary Medical Center in cooperation with RESTORE and presented by Annette Slater, M.D. One hour Category I credit offered. Lunch provided. No fee, but registration required: 660-2810.

### Baptist Memorial Medical Center's Summer Seminar

August 21, 8:30 a.m.-12:30 p.m., Fairfield Bay Resort & Conference Center. Category I credit: 4 hours. Fee: \$20.

## Mental Health Conference:

### Sexual Abuse: Signs, Symptoms and Treatment Options

September 17, 12:00 noon-1:00 p.m., dunkerton Room, Center for Health Education, St. Vincent Infirmary Medical Center. Sponsored by Office of Continuing Education, St. Vincent Infirmary Medical Center and RESTORE and presented by Karen Boyd Worley, Ph.D. One hour Category I credit. Lunch provided. No fee, but registration required. Call RESTORE, 660-2810.

### The Impact of AIDS on Minorities in Arkansas

September 25, 9:00 a.m.-4:30 p.m., ED II Building, UAMS. Sponsored by American Red Cross, Arkansas

Department of Health, Delta Region AIDS Education and Training Center (UAMS), Veterans Administration AIDS Program. Fee: \$10 (lunch and parking included); 6 CEU. For more information, call 686-5585.

### Nutrition & Aging IX: Vitamins and Minerals in Health Disease

September 29, 8:00-8:30 a.m. registration, Excelsior Hotel, Little Rock. Sponsored by UAMS College of Medicine and presented by Ronnie Chernoff, Ph.D. and David Lipschitz, M.D., Ph.D. Registration fee: \$165; VA employees: \$75.

### Primary Care Update 1993

October 22, time to be announced, Baptist Medical Center, J.A. Gilbreath Conference Center, Little Rock. Presented by Baptist Medical Center, Medical Affairs. Further information to be announced.

### Tenth Annual Conference on Perinatal Care

November 4-5, time to be announced, Excelsior Hotel, Little Rock. Sponsored by UAMS College of Medicine and presented by Dr. J. Gerald Quirk. Category I credit to be announced.

### Surgery for Cleft Lip and Cleft Palate

November 18-21, time to be announced, Arkansas Children's Hospital Conference Center, Little Rock. Sponsored by UAMS College of Medicine and presented by Dr. Robert Seibert. Category I credit offered: 17.25 hours.

## Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

### FAYETTEVILLE-VA MEDICAL CENTER

Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

### HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, Sept. 10 & 24, Oct. 8 & 22, 12:30 p.m., AMI Ozark - Quapaw Room



### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar*, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
*Genetics Conference*, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
*Infectious Disease Conference*, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
*Pediatric Grand Rounds*, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
*Pediatric Neuroscience Conference*, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
*Pediatric Pharmacology Conference*, 5th Wednesday, 12:00 noon, 2nd Classroom  
*Pediatric Research Conference*, 1st Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
*Journal Club*, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Chest Conference*, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon, CARTI Auditorium. Lunch provided.  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Hematology-Oncology Conference*, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Cancer Center Team Conference*, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*Breast Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*GI Conference*, 4th Friday, 11:30 a.m., Conference Room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

### **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Chest & Problems Case Conference*, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Medicine Conference*, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Surgery Conference*, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Tumor Conference*, 1st Thursday, 12:00 noon, Assembly room. Lunch provided.  
*X-ray Case Conference*, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

### **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room

*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institut  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

#### **EL DORADO-AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas



*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

#### **DAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

#### **FORT SMITH-AHEC**

*Advances in Plastic Surgery*, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Tuesdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center

#### **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Harris Hospital Tumor Conference*, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

#### **SPRING BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

#### **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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# Information for Authors

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All manuscripts should be submitted to Cindy Sawrie, Managing Editor, Arkansas Medical Society, P.O. Box 5776, Little Rock, Arkansas 72215. A transmittal letter should accompany the article and should identify one author as the correspondent and include his/her address and telephone number.

## MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

Along with the typed manuscript, we encourage you to submit an IBM-compatible 5 1/4" or 3 1/2" diskette containing the manuscript in ASCII format. The manuscript on diskette must be in the same format as stated above. We will return the diskette upon request.

## REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the authors(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

## ILLUSTRATIONS

Illustrations should be professionally drawn and/or photographed. Glossy black and white photos are preferred. They should not be mounted and should have the name of the author(s) and figure number penciled lightly on the back. An arrow should indicate the top of the illustration. In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material. Up to four illustrations will be accepted at no charge to the author(s). If more than four are necessary, it is understood that the author(s) will be responsible for the reproduction costs.

## REPRINTS

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# Networking

Ben N. Saltzman, M.D.\*

The term "Networking" is not often used these days, but the principle persists. Following the end of World War II, planners in the field of Health and Health Services coined the word to represent groups of cooperating people working together to provide solutions to meet the health needs of the people. Of course, others were doing the same thing in other endeavors, but I want to limit my remarks to my own experiences and to the results of the application of the principle.

Soon after becoming a member of the Arkansas Medical Society in 1946 following the end of my Army medical service, I was appointed a member of the Committee on Rural Health of the Society. The appointment was based on the fact that I was in a solo practice in Mountain Home, a town of 1,200 people as far north in Arkansas as you can get from Little Rock.

To help us in planning, an advisory committee of non-physicians was appointed to inform us of the health needs of the rural communities and to make suggestions on a grass roots level to meet those needs. The advisory committee consisted of leaders in the Cooperative Extension Service, the Farm Bureau, the Arkansas Power & Light Company, The Arkansas Dental Association, the P.T.A., Blue Cross Blue Shield, the Extension Homemakers, and the Medical Society Auxiliary. We met on a regular basis. We planned and implemented State Rural Health Conferences involving physicians and lay leadership of the rural counties and communities and enumerated their needs and made recommendations for self-help. Of course, the chief need in the eyes of the rural people was the lack of sufficient medical care in the form of physicians.

We "networked" with the Council on Rural Health of the American Medical Association and found that

this group had an Advisory Committee similar to ours but on a national level. In some cases their members were borrowed from us. I had the privilege of serving on the Council for a period of ten years. We participated in National Rural Health Conferences over the country and learned that we were not alone in our rural health problems. Over the years, our problems have not been solved, but progress has been made. We have better roads, better transportation, and have instilled more awareness of the problems in the minds of our local, state and national leaders.

The chairman of our Arkansas Advisory Committee was Mr. C.A. Vines, Director of the Arkansas Cooperative Extension Service at that time. He was a national leader and international consultant in Extension. He gave freely of his time, energy and knowledge and was invaluable to our medical committee. Through him, I learned more about the work of Extension, particularly in relation to its 4-H Program. 4-H is the youth development phase of the Cooperative Extension Service, University of Arkansas.

4-H provides educational training through project work, leadership and citizenship programs, and 4-H activities. "Learning by doing" is stressed as the most practical way of helping youth learn.

The 4-H's are HEAD (acquisition of knowledge), HEART (community service and leadership activities), HANDS (skills), and HEALTH (enhancement of physical, mental, and social health). The program is designed to help youth with their total development, consisting of "personal growth in knowledge, skills, and attitudes."

The 4-H Program included annual District and Statewide 4-H Oramas in which I was invited to participate. I helped with the judging of health projects and the awarding of prizes related to health. The Arkansas Medical Society has for many years been supportive of this program.

In 1951 an Arkansas 4-H Foundation was organized. The original Board of Trustees consisted of eight

\* Dr. Saltzman, retired family practitioner in Mountain Home, is currently a member of the Editorial Board for *The Journal of the Arkansas Medical Society*.

members. Mr. Vines was appointed executive director. I became a trustee soon after its organization. Upon his retirement as director of the Arkansas Cooperative Extension Service, Mr. Vines as executive director of the 4-H Foundation Board, brought to the Board his concept of the development of a 4-H Center for Arkansas. Quoting from a short history of the Arkansas 4-H Center, "The C.A. Vines 4-H Center is not something that just happened. 4-H enrollment grew from slightly over 26,000 in 1970 to more than 60,000 in 1980. The number of volunteer leaders grew in the same proportion to more than 8,000, so did the quality of teaching. During the decade of the '70s, county Extension agents, volunteer 4-H leaders, 4-H faculty, and others saw the need for such a center. The movement kept gaining momentum, which led to the purchase of 228 acres of land (Ferndale) on April 30, 1976. The ensuing 15 years have seen the development of what is probably the best 4-H Center in the nation at a cost of approximately \$6 million.

The construction of this center was financed by voluntary donations, along with dollar for dollar matching grants from the Arkansas Legislature on a step-by-step basis. As of this date, the C.A. Vines 4-H Center is

complete and is debt-free. Clientele of the Center are charged a small service fee which sustains expenses and upkeep. In recent years, more than 20,000 people have registered for training at the Center annually."

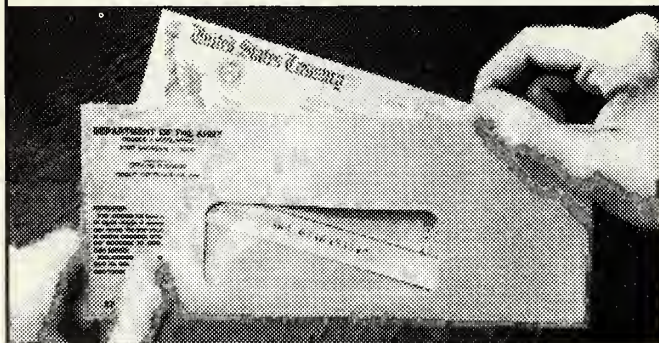
There is a tendency to want to go on and on with the accomplishments of 4-H and the center, but that is not the purpose of this editorial. It was written to provide only one example of how effective "Networking" can be. Several people who served on our board are veterans of the original Rural Health Advisory Committee. The newer members are of a caliber that fit the mold.

When we contrast the behavior and accomplishments of the young people between the ages of nine and nineteen in the 4-H Program who go on to leadership on a local, state or national basis with those that we see and read about on a daily basis, we must ask ourselves, why the difference?

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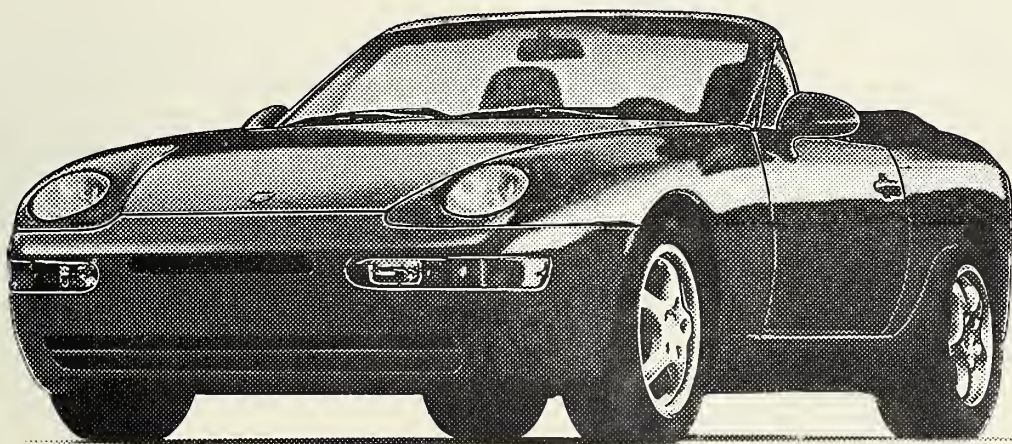
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# Transjugular Intrahepatic Portosystemic Shunt (TIPS) in the Management of Variceal Hemorrhage

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## ABSTRACT

Transjugular intrahepatic portosystemic shunt placement is a new non-operative therapeutic procedure used by interventional radiologists to manage patients with variceal hemorrhage who are unresponsive to medical treatment. This procedure offers an alternative to surgical shunt procedures with a much lower morbidity and mortality and has a high success rate in controlling bleeding. The early experience at St. Vincent Infirmary Medical Center is discussed.

## INTRODUCTION

The management of variceal hemorrhage secondary to portal hypertension is a difficult problem. About 50% of cirrhotic patients will develop varices, and of these, half will hemorrhage. The reported mortality rates for the initial bleed and each rebleeding episode average 30-40%.<sup>1</sup> Medical management includes the use of oral propranolol (as a prophylactic agent), or, in the acute setting, intravenous pitressin, mechanical tamponade with the Sengstaken-Blakemore tube, and endoscopic sclerotherapy. Transhepatic portal vein catheterization with variceal embolization has been used by some radiologists to stop acute hemorrhage, but this, as well as all other medical treatments, has a high frequency of recurrent bleeding because the elevated portal pressures have not been altered.

There are multiple surgical portosystemic shunts currently employed which have a low incidence of rebleeding including the distal splenorenal shunt, portacaval shunt, and mesocaval shunt. The morbidity and mortality of these surgical shunts, as well as their technical difficulty, however, has generated interest in developing an easier and safer means of portal decompression.

The first attempt to create a percutaneous portosystemic shunt was described by Josef Rosch et al in 1969.<sup>2</sup> Rosch created parenchymal tracts between the inferior vena cava and portal vein in pigs. The first human application was reported by Colapinto et al in 1983, who used balloon dilatation to open a parenchymal tract between branches of the hepatic vein and portal vein.<sup>3</sup> Early shunt occlusion due to closure of the parenchymal tracts limited the usefulness of this technique.

In 1985, Palmaz et al developed a good canine model of portal hypertension and applied expandable metallic stents to hold open the parenchymal tracts created between the hepatic vein and portal vein. Success in the canine model led to clinical application in humans beginning in 1988. Currently, there are multiple centers accumulating experience with the procedure known as Transjugular Intrahepatic Portosystemic Shunt (TIPS).

## PATIENTS AND METHODS

Patients with variceal hemorrhage unresponsive to medical management are eligible for TIPS under our protocol as approved by the Institutional Review Board at St. Vincent Infirmary Medical Center. Patients undergo a complete medical evaluation by a gastroenterologist. A surgical consultation is obtained to evaluate each patient in regards to selection of surgical shunt versus TIPS, and also to provide surgical backup as TIPS is performed. Angiographic evaluation and TIPS are performed in the angiography lab by the radiologic investigators. Diagnostic arteriography and measurement of hepatic wedge pressures may be done the day prior to the planned TIPS procedure, or the diagnostic studies and shunt placement may be done as a single procedure. TIPS may be placed acutely in patients with active variceal hemorrhage and are usually placed in patients with a patent portal venous system; however,

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portal vein thrombosis is not an absolute contraindication as it may be possible to recanalize the occluded portal vein using interventional radiologic techniques.

Prophylactic broad spectrum antibiotics are given prior to TIPS and severe coagulopathies are corrected. TIPS is performed using local anesthesia and intravenous analgesia such as Fentanyl and Versed. A 10 French sheath is placed via the right internal jugular vein into either the right or middle hepatic vein. A modified 16 gauge Colapinto needle (Cook, Inc., Bloomington, IN) or a 5 French coaxial catheter-needle system (Cook, Inc., Bloomington, IN)<sup>5</sup> is advanced through the wall of the hepatic vein into the central right or left portal vein. A guidewire is then passed through the needle and advanced into the splenic vein or superior mesenteric vein allowing placement of an angiographic catheter. Simultaneous pressures are then obtained from the portal venous system and the hepatic vein to determine the baseline portosystemic pressure gradient. A portogram is obtained to assess portal venous anatomy and flow, as well as evaluate the presence and extent of varices. The parenchymal tracts are dilated with a standard angioplasty balloon, and one or more expandable metallic stents are deposited along the tract. We have used both Palmaz stents (Johnson and Johnson International Systems, Warren, NJ) and Wallstents (Schneider, USA, Minneapolis, MN), although currently our preferred stent and the most commonly used stent by other investigators is the Wallstent. All stents were initially expanded to 8mm in diameter, then the portogram and pressure measurements were repeated. Attempt is made to achieve a portosystemic gradient less than 15mm Hg. If the 8mm diameter shunt is inadequate, the stents may be further expanded to 10 or 12mm as necessary using an appropriate size balloon. The ability to "size" the shunt is a distinct advantage of TIPS over surgical shunts.

The most critical step in the creation of an intrahepatic shunt is localization of an appropriate portion of the portal venous system for puncture. One technique we have used on three patients is the placement of a small catheter into the portal system by ultrasound-guided puncture of the left portal vein. We have used the Accustick Introducer System (MediTech, Watertown, MA) puncturing the left portal vein with a 21 gauge needle and placing an 0.018" platinum-tipped wire into the right portal vein as a target. (At the time of stent deployment, the inner [4 French] dilator is placed in the portal vein to allow contrast injection to accurately place the stents.) The small transhepatic tract is embolized with Gelfoam to minimize the risk of bleeding. We have not observed bleeding in our patients and feel that the risk is low even in patients with coagulopathies and/or ascites. In one case, we used the technique of Harmon et al placing an 0.018" platinum microcoil adjacent to the portal bifurcation by ultra-

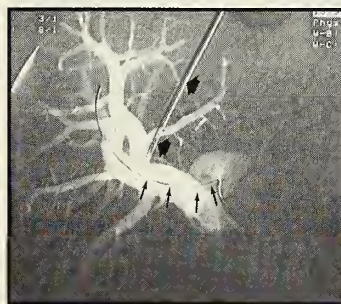
sound guidance to use as a marker during fluoroscopic puncture of the portal vein.<sup>6</sup>

Following a successful TIPS, a baseline doppler ultrasound study of the shunt is obtained. Follow-up doppler studies can be done to compare flow velocities and color-flow images allowing detection of shunt stenosis or occlusion. Shunt catheterization can also be performed from a femoral vein approach for direct angiographic evaluation and pressure measurements.

## CASE PRESENTATIONS

Transjugular intrahepatic portosystemic shunts were placed in four patients at St. Vincent Infirmary Medical Center between February, 1992 and February, 1993. All were complex management problems which were treated with successful TIPS placements.

**CASE 1** is a 69-year old male with alcoholic cirrhosis and esophageal cancer who had multiple episodes of variceal bleeding over a several year period and had undergone radiation therapy for his esophageal cancer. A stricture of the distal esophagus developed which prevented intake of solids. A permanent gastrostomy was not an acceptable option to the patient, and, because large varices were evident endoscopically, portal decompression followed by esophagogastrectomy was planned. Due to his underlying malignancy and compromised medical condition, TIPS was favored over a surgical portosystemic shunt. On the day prior to the electively scheduled TIPS, the patient was admitted with a variceal hemorrhage. He was stabilized, and TIPS was performed four days after admission. The initial portosystemic gradient was 30mm Hg (Fig. 1A) Following placement of Palmaz stents at 8mm diameter, the gradient was 19mm Hg. The stents were dilated to 10mm, and the gradient reduced to 15mm Hg (Fig. 1B)



1A. Initial portogram obtained through the Colapinto needle (large arrows). The platinum guidewire (small arrows) used as a target is seen entering the left portal vein and extending across to the right portal vein.



1B. Portogram following shunt placement shows a patent shunt (arrows) from the right portal vein to the middle hepatic vein.



Nine days post-shunt, an EGD demonstrated the obstructing esophageal cancer; however, no varices were present. Twelve days post-shunt, he underwent an esophagogastrectomy with colon interposition. The surgery was tedious because of radiation fibrosis, but no varices were encountered and no unusual bleeding occurred. Unfortunately, the post-op course was marked by respiratory decompensation, progressive liver failure, the hepatorenal syndrome, and death 16 days post-surgery, 28 days post-shunt.

**CASE 2**, a 75-year old woman with severe COPD, alcoholic cirrhosis with marked ascites, and multiple episodes of both variceal hemorrhage and bleeding from duodenal AVM's, was admitted with a variceal hemorrhage stopped by intravenous pitressin. She underwent TIPS uneventfully with a final portosystemic gradient of 12mm Hg at 10mm diameter shunt (Fig. 2A, B). The patient was discharged on the third day post-shunt with no further bleeding and a considerable decrease in the amount of ascites.

At a 2-month follow-up ultrasound examination, a significant intrastent stenosis had developed which was confirmed by portal venogram and treated simply by balloon angioplasty with good results and a decrease in portosystemic gradient from 26mm



2A. (Above top) Initial portogram shows large varices (small arrows) and a large, recanalized umbilical vein (large arrows).

2B. (Above) Following shunt placement (large arrows), variceal filling is markedly diminished (small arrows).



2C. Intrastent stenosis (small arrows) developed at 2 months and there is considerable filling of varices (large arrows).

Hg to 11mm Hg (Fig. 2C, D). Stenosis within the stents recurred at 6 months, and this again responded to angioplasty; however, the patient died during that admission of respiratory failure and gastrointestinal bleeding.



2D. Following angioplasty, there is no residual stenosis within the stents (small arrows) and variceal filling is decreased (large arrows).

**CASE 3** is a 44-year old man with alcoholic cirrhosis and repeated variceal bleeds who underwent a distal splenorenal shunt in April, 1990. This shunt occluded and, because of recurrent variceal bleeding, he underwent a mesocaval shunt in May, 1990. Recurrent hemorrhage prompted repeat angiographic evaluation, showing a stenotic mesocaval shunt with extensive gastroesophageal varices. In November, 1990, he underwent a splenectomy and ligation of varices.

The patient was admitted in March, 1992, with recurrent variceal hemorrhage, and repeat angiography showed a thrombosed mesocaval shunt with segmental occlusion of the superior mesenteric vein and multiple small gastroesophageal varices.

TIPS was performed on the eighth hospital day with an initial portosystemic gradient of 25mm Hg reduced to 9mm Hg with the Palmaz stent dilated to 8mm. He was discharged on the third post-shunt day without problems.

The patient clinically did well with shunt patency documented until routine ultrasound follow-up at one year showed the shunt to be occluded and new ascites had developed. Following multiple unsuccessful transvenous attempts to catheterize the shunt from both the femoral and right internal jugular vein approaches the left portal vein was catheterized via a transhepatic approach. Direct portogram demonstrated shunt occlusion, and the portal pressures were elevated with a portosystemic gradient of 18mm Hg (Fig. 3A).

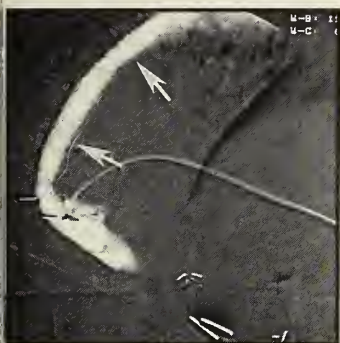
The occluded Palmaz stent was catheterized and predilated with a 5mm balloon, allowing placement of a long Wallstent from the hepatic vein near the IVC through the occluded stents and to the junction of the left portal vein and main portal vein. The Wallstent was dilated to 10mm, and the portosystemic gradient reduced to 7mm Hg (Fig. 3B). The transhepatic tract was embolized with Gianturco coils and no complication occurred.

Although there have been many cases of occluded shunts being recanalized using thrombolysis and/or





3A. (Left top) Transhepatic portogram via the left portal vein (small arrows) demonstrates occlusion of the shunt (large arrows).  
3B. (Left bottom) Following recanalization of the occluded stents and placement of a Wallstent, the shunt is widely patent (arrows).



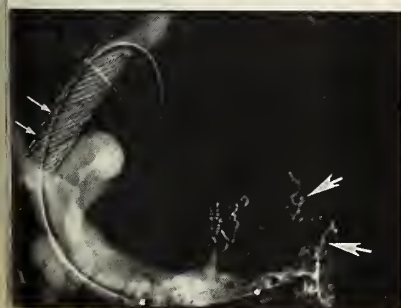
angioplasty and further stent placement, all reported cases, to our knowledge, have been accomplished via a transvenous route. The anatomy of the hepatic vein stenosis in our case prevented successful catheterization so the transhepatic approach was used with success.

This approach is similar to that used for recanalizing occluded portal veins, allowing successful TIPS placement.

**CASE 4**, a 55-year old male with post-hepatic cirrhosis, was admitted with variceal hemorrhage in February, 1993. Bleeding was initially controlled with intravenous pitressin. Because of the extent of varices, endoscopic sclerotherapy was thought unlikely to be adequate, and TIPS was performed while the patient remained on pitressin. Localization of the portal vein for puncture was done with ultrasound, and an 0.018" platinum microcoil was placed adjacent to the central right portal vein through a 21 gauge needle. This localization



4A. Initial portogram shows a large coronary vein (large arrows) filling gastroesophageal varices. Note the platinum microcoil target (small arrows) adjacent to the right portal vein.



4B. After placement of a Wallstent shunt (large arrows), there is filling of tiny retroperitoneal collateral veins (small arrows), but no further filling of the coronary vein.

step took about five minutes and greatly facilitated the puncture of the right portal vein from the right hepatic vein.

Following preliminary tract dilatation, a 94mm long 10mm diameter Wallstent was placed with the portosystemic gradient reduced from 20mm Hg to 11mm Hg. Prominent gastroesophageal varices visualized on the initial portogram were no longer filled after successful shunt placement. (Fig. 4A, B) Pitressin was discontinued and no further bleeding occurred. After TIPS, the patient had unexplained fevers for six days which gradually resolved on broad-spectrum antibiotics, although multiple blood cultures were negative.

Prior to TIPS, the patient had thrombocytopenia with a platelet count of 64,000 on admission. This was attributed to increased splenic consumption from congestion. The platelet count immediately improved following shunt placement; and at one-month and two-month follow-up visits, the counts have averaged 100,000.

## DISCUSSION

TIPS can be performed safely, either electively or acutely, in patients who are not good surgical candidates. Since passage of the Colapinto needle or coaxial catheter-needle system and stent placement are intrahepatic, the risk of intraperitoneal bleeding from the procedure is very low, even in patients with abnormal coagulation parameters. The presence of ascites is not a problem as it can be with transhepatic embolization procedures.

Technical success in placing an intrahepatic shunt using these techniques has been reported in 90-100% of patients.<sup>7,8</sup> Almost all patients with a successful TIPS will have cessation of bleeding. Some patients have had varices embolized at the time of shunt placement as this is very easily accomplished once access to the portal vein is achieved. Most investigators feel that embolization is not required if an adequate shunt is created.

An intrahepatic shunt is very useful in patients with variceal hemorrhage who are awaiting a liver transplant.<sup>9</sup> A successful TIPS placement may avoid the complications of variceal hemorrhage and the need for emergency transplantation, allowing the patient to wait for a suitable donor. The presence of an intrahepatic shunt does not significantly complicate liver transplantation, whereas the presence of a surgical portacaval shunt greatly increases the technical difficulty of transplant surgery.

TIPS may be useful in patients with intractable ascites from portal hypertension. Zemel et al reported on their 25 patients, 17 of whom had ascites.<sup>7</sup> All 17 had relief of ascites following successful TIPS. In the future, TIPS may prove to be a more effective way to manage ascites in these patients than is peritoneo-venous shunting.



## COMPLICATIONS

Shunt stenosis and occlusion have been reported on average in 10-30 percent of cases, and most can be successfully managed using interventional angiographic techniques.<sup>7,8</sup> If stenoses develop on either end of the shunt or within the stents, they may be successfully treated either with balloon dilatation alone, as in our Case 2, or with further stent placement, as in Case 3. Urokinase thrombolytic therapy may be useful in shunt thrombosis. Recurrent variceal hemorrhage after successful TIPS suggests the possibility of shunt stenosis or thrombosis and warrants angiographic evaluation, although the majority of these patients with recurrent bleeding will have a source other than varices, e.g., ulcer, gastritis, Mallory-Weiss tear.

A significant potential risk with TIPS, as with surgical shunts, is the development of hepatic encephalopathy or progressive hepatic deterioration. To date, these have not been reported as frequently with TIPS as they are with nonselective surgical shunts. Various investigators have reported encephalopathy in between 8 and 20% of patients,<sup>7,8</sup> almost all of whom were well controlled on a low protein diet and lactulose. These rates are more similar to rates achieved after distal splenorenal shunt and considerably lower than portacaval or mesocaval shunts. The relatively low incidence and severity of encephalopathy may be due to the small caliber of the shunt.

In performing TIPS placement, the goal is to achieve a sufficient reduction in portal pressure to decompress the varices and prevent bleeding, yet maintain adequate hepatic portal perfusion to avoid encephalopathy. Further experience will provide more information on the optimum shunt caliber and portosystemic gradient to achieve. Current end point guidelines stem from reported surgical series, including that of Warren et al, who reported no recurrent variceal hemorrhage after distal splenorenal shunt with a portosystemic gradient of less than 12mm Hg.<sup>10</sup>

In addition to the risk of encephalopathy other potential risks from TIPS include sepsis, hemorrhage, disseminated intravascular coagulopathy, puncture site bleeding or thrombosis, and contrast reactions or toxicity, although all of these are uncommon. Most of the morbidity and mortality in patients receiving intrahepatic shunts is related more to the extent of hepatic dysfunction and overall medical condition, rather than the TIPS procedure.

## SUMMARY

Transjugular intrahepatic portosystemic shunt placement is an exciting new procedure to offer cirrhotic patients with variceal hemorrhage and potentially to those with intractable ascites due to portal hypertension. TIPS can be performed with low morbidity and mortality and a high degree of technical and

clinical success. TIPS is becoming the preferred procedure over surgical shunts at many institutions and may be very useful as a temporizing measure in patients awaiting liver transplantation. Although there is a significant incidence of shunt stenosis or occlusion, these can frequently be salvaged by further interventional techniques. For the unusual case in which transvenous access to the failed shunt is impossible, the transhepatic approach may prove valuable.

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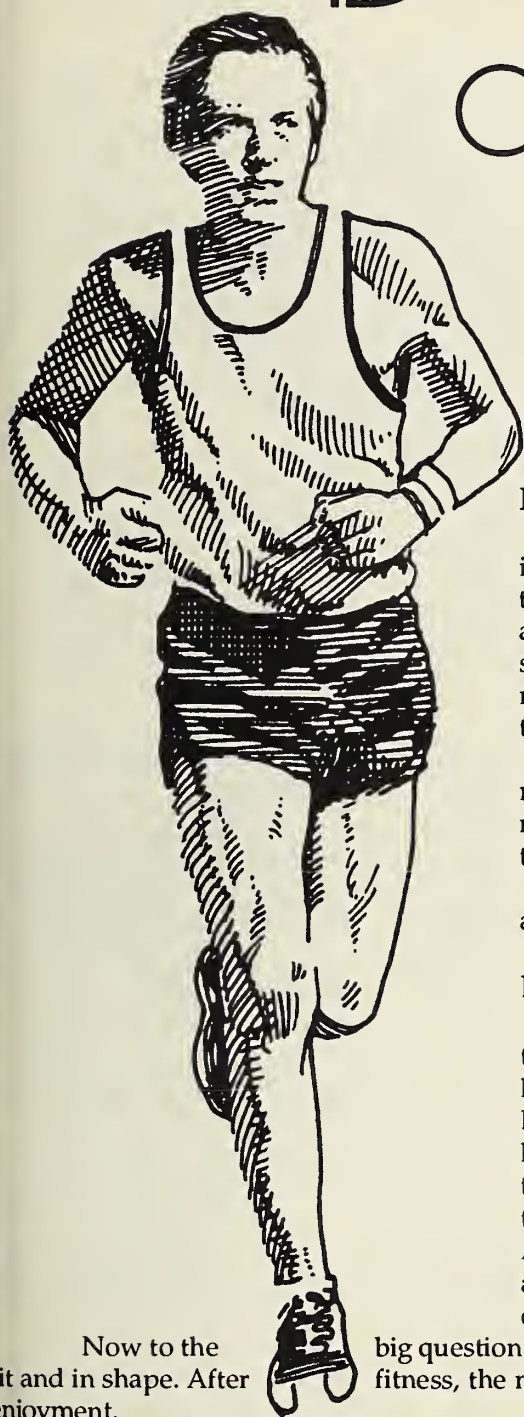
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# Doctors on the *RUN*

Fred Reddoch



## INTRODUCTION

A fast-paced lifestyle and the practice of medicine usually go hand in hand; but for the doctors featured in this article, "fast-paced" is more than just a figure of speech. Why? Because these doctors are runners, and many of them run at a very fast pace. Some race competitively; some run marathons and longer distances; some simply jog around the neighborhood for fun and fitness; but all have one thing in common - they love to run!

To learn the "what, where, when, how and - especially - why" they run, questionnaires were sent to every Pulaski County Medical Society member who could be identified as a runner. Over three-fourths of the thirty-one questionnaires sent out were returned.

The purpose of this article is to highlight some of the data collected and to give you a profile of the "average" physician runner.

## DATA ANALYSIS

The doctors participating in the survey ranged in age from thirty-three to sixty-nine, with the average age being forty-seven. All but six have been running for ten years or more. Drs. Troy Barnett, Barry Baskin, Dean Kumpuris, Barre Finan, Steve Tucker and Wick Marvin have been racking up the miles for over two decades. Most of them run three or four times a week totalling twenty-five miles. Dr. John Baber, the most consistent of the group, seldom misses a day of running. Averaging 50+ miles a week, Steve Tilley, Jim Morse, Bob McGowan and Bob Galbraith put more mileage on their feet than some people put on their cars!

Now to the big question - "Why?" The number one reason given was a desire to be aerobically fit and in shape. After fitness, the most frequently given reasons were stress relief, weight control and enjoyment.

Most of the doctors questioned compete in local 5K (3.1 mile) and 10K (6.2 mile) races. Drs. Morse, Baskin, Finan, Galbraith, Bob Moore and Jeff Carfagno have all attained the goals that many runners aim for - a sub-twenty minute 5K and a sub-forty minute 10K. Dr. Tilley (16:08 5K; 33:17 10K) and Dr. McGowan (16:20; 35:45) have run some very fast races. And who is the fastest? Family physician Steve Tucker owns an incredibly fast 15:17 5K and 31:58 10K. A 31:58 10K means running 6.2 miles at just over a five minute per mile pace!

Ten of the twenty-four doctors in the survey have run a marathon (26.2 miles). Drs. Tilley, Morse, Barnett and Moore have run Boston. Dr. Moore, who ran it from 1984-86, describes it as follows: "To be participating in a world

class event so filled with tradition; and to run between the supportive, cheering populace; and to complete that arduous race, cross the finish line in front of the "Pru" (Prudential Building), is an unforgettable moment. It was analogous to being a participant in the World Series, or Super Bowl, or Kentucky Derby - the pinnacle." Drs. Baskin, Galbraith and Tucker have completed the Pikes Peak Marathon and Dr. Gunnar Gibson ran the 1992 "Rim to Rim" Grand Canyon Marathon. Dr. Tucker completed the Western States one-hundred mile race, which featured high altitudes, snow, river crossings and one-hundred plus degree heat! Drs. Carfagno and Finan "subspecialize" in triathlons, which include running, biking and swimming. Dr. Finan swam 2.4 miles, biked 112 miles, and ran 26.2 miles to finish the grueling Canadian Ironman Triathlon. Arguably the toughest of these medical marathoners is Dr. McGowan. He is a veteran of twenty-five marathons, including Pikes Peak, Grand Canyon and six Ironman Triathlons!

When asked to describe their most memorable race or run, Drs. Charles Logan and Bruce Schratz both indicated a fondness for Little Rock's BudRun (formerly the Pepsi 10K) and the sense of accomplishment they experience in finishing the hilly course. Dr. Eric Fraser will never forget running next to an elderly woman who talked nonstop but didn't elicit a sound from Dr. Fraser. Why? Because if he had used up his oxygen and energy talking he wouldn't have been able to keep up with her! Dr. Dean Kumpuris' claim to fame is "when I beat Bill Clinton in the Pepsi!" Dr. John Hampton echoes the feeling of many runners by saying: "All my runs are memorable if I finish them!"

What keeps these physicians motivated to continue running? For many, it's striving for a particular goal. Drs. Ted Saer and Nancy Rector want to run a marathon someday. Dr. Marvin Leibovich has two goals: to keep up with his fifteen year old son who runs and to run a marathon on his sixty-fifth birthday! Dr. Morse wants to "run into the seventh decade of life," while Dr. Byron Curtner simply wants to "continue jogging for many years."

Responding to the question - "Is there any sense in which you feel that running makes you a better doctor?" - nearly all of the respondents said yes. For Dr. Leibovich and Dr. Fraser, running provides them with energy to pull the long hours typical of their specialties - emergency medi-

cine and pediatrics. Like Tyler Baber and Cary Crawford, a number of doctors felt that the reduction in stress derived from running made them better, more relaxed doctors. Dr. Rector replied that being a runner "allows me to talk authoritatively with patients regarding exercise programs; sets an example regarding a healthy lifestyle."

## THE "AVERAGE" PHYSICIAN RUNNER

Based on the data collected, a profile of the "average" physician runner can be drawn: He is forty-seven years old; has been running fourteen years; runs three or four times a week about five or six miles at a time; he runs primarily to stay in shape and reduce stress; has never run a marathon but runs 5K and 10K races at about an eight minute pace; he feels that the psychological benefits make him a better doctor; he plans to run for many more years.

## CONCLUSION

The physical and psychological benefits of regular exercise are well known. Finding time for exercise, however, is difficult for all of us; and especially difficult for busy doctors. The doctors featured in this article set an example for their peers and patients alike. They are proof that no matter how busy you are, you can make exercise a part of your regular schedule.

<u>NAME</u>	<u>AGE</u>	<u>SPECIALTY</u>
John C. Baber	68	General Surgery
J. Tyler Baber	43	Gastroenterology
Troy F. Barnett	50	Urology
Barry D. Baskin	39	Physical Med/Rehab
Jeffrey J. Carfagno	34	Family Practice
Cary M. Crawford	34	Family Practice
Byron Curtner	35	Family Practice
Barre F. Finan	40	Urology
Eric A. Fraser	44	Pediatrics
Robert C. Galbraith	52	Neurology
Gunnar Gibson	39	Dermatology
John R. Hampton	51	Pulmonary Disease
D. Dean Kumpuris	45	Gastroenterology
Marvin Leibovich	46	Emergency Medicine
Charles W. Logan	58	Urology
H. N. "Wick" Marvin	48	Family Practice
Robert J. McGowan	52	Family Practice
Robert B. Moore	56	Internal Medicine
Jim C. Morse	50	Internal Medicine
Nancy F. Rector	48	Pulmonary Diseases
Edward H. Saer	42	Orthopaedic Surgery
Bruce E. Schratz	60	Family Practice
Stephen B. Tilley	46	Family Practice
R. Stephen Tucker	40	Family Practice



# Discover The Elegance Of A Hybrid



At first glance, it's the *beauty* of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its *elegance* becomes apparent—a gentle blend of softness and strength.

At first glance, it's the *enhanced performance* of Vaseretic that catches the eye. But study Vaseretic more closely, and its *elegance* becomes apparent. The way its one-tablet, once-a-day dosage minimizes multiple

medications. Minimizes insurance copayments. And minimizes potassium supplementation.

A hybrid *blending of tolerability and power* that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

And an elegant discovery for your practice.

**IN PREGNANCY:** When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury even death to the developing fetus. When pregnancy is detected, Vaseretic (enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. **WARNINGS, Fetal/Neonatal Morbidity Mortality.**

**VASERETIC® 10-25**  
Enalapril Maleate-Hydrochlorothiazide

*Next*

Dosage must be individualized; the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.



**TABLETS  
VASERETIC®  
(ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)**

**USE IN PREGNANCY:** When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

**CONTRAINDICATIONS:** VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

**WARNINGS:** General, Enalapril Maleate; Hypotension: Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, Drug Interactions, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

**Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 0.3 mL to 0.5 mL and/or measures necessary to ensure a patent airway, should be promptly provided. (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

**Neutropenia/Agranulocytosis:** Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, Drug Interactions, Enalapril Maleate and Hydrochlorothiazide).

**Pregnancy:** Enalapril-Hydrochlorothiazide: There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 1/2 times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 1/2 times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality, below.)

**Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality:** ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no

10  
mg



25  
mg

alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intrauterine environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

**Hydrochlorothiazide; Teratologic Effects:** Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5.6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

**Nonteratologic Effects:** These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**PRECAUTIONS:** General, Enalapril Maleate; Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

**Hemodialysis Patients:** Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69®) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

**Hyperkalemia:** Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See Drug Interactions.)

**Cough:** Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, i.e., muscle fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

**Hypokalemia** may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see Drug Interactions, Agents Increasing Serum Potassium).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the

treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt. In some cases, hyponatremia may be life-threatening. In such cases, prompt and appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postoperative patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidenced by hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

**Information for Patients: Angioedema.** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggestive of angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indications of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**Pregnancy:** Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, they should also be told that these consequences do not appear to be related to intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

**NOTE:** As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

**Drug Interactions: Enalapril Maleate; Hypotension—Patients on Diuretic Therapy:** Patients on diuretics and especially those in whom diuretic therapy has been recently instituted, may occasionally experience an excessive reduction in blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

**Agents Causing Renin Release:** The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** Enalapril has been used concomitantly with beta adrenergic-blocking agents, methylglucosides, nitrates, calcium-blockers, hydralazine and prazosin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, amiloride, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

**Lithium:** Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium. Hydrochlorothiazide: When administered concurrently the following drug may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Cholestyramine and colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively. Thiazides may be administered two to four hours before the resin when the two drugs are used concomitantly.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of preparations with VASERETIC.

**Non-steroidal Anti-inflammatory Drugs:**—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agent are used concomitantly, the patient should be observed closely to determine if a desired effect of the diuretic is obtained.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

\* Registered trademark of Hospital Ltd.



bone marrow assay.

**Enalapril Maleate:** There was no evidence of a tumorigenic effect when enalapril was administered for 06 weeks to rats at doses up to 90 mg/kg/day (150 times\* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times\* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 100 mg/kg/day of enalapril.

**Hydrochlorothiazide:** Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

**Pregnancy:** Pregnancy Categories C (first trimester) and D (second and third trimesters). See WARNINGS, Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.

**Nursing Mothers:** Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

**Lactation Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body as a Whole:* Syncope, chest pain, abdominal pain; *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric:* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash; *Other:* Dyspnea, gout, back pain, arthralgia, arthralgia, decreased libido, tinnitus, urinary tract infection.

**Angioedema:** Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

**Hypotension:** In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (1.5 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

**Cough:** See PRECAUTIONS, Cough.

**Clinical Laboratory Test Findings, Serum Electrolytes:** See PRECAUTIONS.

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

**Serum Uric Acid, Glucose, Magnesium, and Calcium:** See PRECAUTIONS.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

**Liver Function Tests:** Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

**Enalapril Maleate—Enalapril** has been evaluated for safety in more than 10,000 patients. In clinical trials diverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body as a Whole:* anaphylactoid reactions (see PRECAUTIONS, Hemodialysis Patients); *Cardiovascular:* Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic [unproven]), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression, a few cases of hemolysis in patients with G-6-PD deficiency have been reported in which a causal relationship to enalapril cannot be excluded; *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Renal:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and nasopharyngitis, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, alopecia, flushing, photosensitivity; *Special Senses:* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, hearing.

**Miscellaneous:** A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, xanthopsia, photosensitivity, rash and other dermatologic manifestations.

**Fetal/Neonatal Morbidity and Mortality:** See WARNINGS, Pregnancy, Enalapril Maleate, Fetal/Neonatal morbidity and Mortality.

**Hydrochlorothiazide—Body as a Whole:** Weakness; *Digestive:* Pancreatitis, jaundice (intrahepatic cholestatic unclassified), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity:* Purpura, photosensitivity, urticaria, angioedema, angitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; *Special Senses:* Transient blurred vision, xanthopsia.

Based on patient weight of 50 kg.

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.

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# The Pediatric Anesthesiologist as Consultant to the Pediatrician

Raeferd E. Brown, Jr., M.D., FAAP\*

Michael L. Schmitz, M.D.\*\*

## ABSTRACT

Physicians with training in pediatrics and anesthesiology may be useful as consultants to primary care physicians in the community. Pediatricians or family practitioners may encounter patients with chronic or intractable pain that requires multidisciplinary therapy. Local anesthesiologists may encounter children with complex medical disease or unfamiliar syndromes. Information and consultation can be obtained by contacting the Division of Pediatric Anesthesia or the Pain Management Program at Arkansas Children's Hospital.

This discussion emphasizes the knowledge-base associated with the specialty and suggests scenarios in which this knowledge and training might be used.

## DISCUSSION

Anesthesiologists, especially those with training in Pediatrics and Pediatric Anesthesia, represent a useful resource to the pediatrician in the care of routine and critically ill patients. Many pediatric anesthesiologists are board-certified in Pediatrics and Anesthesiology, and some have special expertise in Critical Care Medicine and Pain Management. All care for children daily and see themselves as the child's advocate in the operating room or the intensive care unit. The training process for anesthesiologists provides experience in operating rooms, pain management centers, and intensive care units. For this reason and because of the strong basis of this discipline in clinical physiology and pharmacology, pediatric anesthesiologists are capable of providing useful consultation under a variety of circumstances.

Cardiopulmonary resuscitation is a major focus of training in anesthesiology. All new graduates are certified in Basic Life Support, most in Advanced Cardiac Life Support, and some in Pediatric Advanced Life Support. It is routine for education in Advanced Life Support to be included as a requirement for continued hospital privileges in anesthesiology. Because of this training and the availability of the specialty in individual hospital settings, anesthesiologists should be considered to have relevant knowledge and experience in circumstances where cardiopulmonary resuscitation is required.

Many pediatric anesthesiologists have special competence in Critical Care; all have an inclination to care for critically ill children. Assistance with problems of airway management, ventilation, circulatory assessment and control, and monitoring of physiologic parameters fall within the knowledge base of pediatric anesthesiologists.

Preoperative assessment and intraoperative management of the critically ill pediatric patient, the extremely premature patient, or the patient with superimposed medical disease are, of course, of first importance to the anesthesiologist. Those professionals with special training in Pediatrics, Pediatric Critical Care, and Anesthesiology follow their patients from the ward, ICU, or Emergency Department through the operative suite to the recovery room, ICN, or ICU with skills based on knowledge of the individual operative procedure and the underlying medical condition. The operating room is very different from the nursery, the ward, or even the ICU. Physiological trespass is constant and must be predicted and controlled. Methods used in the care of children in the OR differ greatly from the care given in, for example, the ICN.

With knowledge of the pharmacology of a variety of CNS-active drugs, the sedation of pediatric patients and the management of painful procedures represent special expertise of the pediatric anesthesiologist. From

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placing an IV atraumatically and painlessly to the management of lumbar punctures, bone marrow aspirations, renal biopsies, and endoscopies, the pediatric anesthesiologist is usually capable of providing information useful for reducing patient stress and physician stress.

Pain management is of special interest to all anesthesiologists and is a major goal of the specialty. Pain in the pediatric patient is a major public health problem that has only been recently recognized. Medical patients as well as surgical patients, trauma victims, and burn patients all benefit from the improved management of pain. Technology, techniques, and drugs that may safely be used for the control of pain in every patient are available. All residents in anesthesiology receive training in acute and chronic pain relief. Many pediatric anesthesia fellowships provide experience in pediatric pain centers. Pediatric anesthesiologists, as evidenced by discussions at the Society for Pediatric Anesthesia, the Pediatric Anesthesia subsection of the AAP, and abstracts published by the American Society of Anesthesiologists, feel that acute and chronic pain management are important concerns and may be helpful as consultants in the management of pain.

The safe transport of critically ill infants and children within the hospital for MRI and CT scans is extremely difficult. Such procedures add to our knowledge base concerning the patient's disease process, yet adverse events such as hypoxia and cardiac arrest encountered during transport may slow discharge at least or threaten life at worst. Knowledge of physiologic monitors, disease states, the use of ventilators and breathing circuits, airway management, and hemodynamic support, as well as the minute-to-minute management of vital signs that follows from expertise in anesthesiology, make the pediatric anesthesiologist a useful consultant in the care of critically ill patients requiring transport within large hospitals.

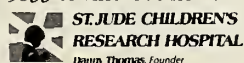
Pediatric anesthesiologists have skills, knowledge, and expertise that can be brought to bear on problems concerning the sickest child. Though the major thrust of anesthesiology is perioperative care, many anesthesi-



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ologists are skilled in Critical Care and Pain Management; most are capable of providing consultation concerning sedation, the management of stressful procedures, and transport; and all are conversant in cardiopulmonary resuscitation. By training and inclination, pediatric anesthesiologists are dedicated advocates of child care and provide a useful resource for pediatricians in the care of their patients.

Physicians who experience problems with critically ill pediatric patients may derive assistance through the department of anesthesia of most major medical centers and all children's hospitals. Many medical centers have physician access lines, which provide information regarding the availability of specific practitioners. Anesthesiologists with a specialized knowledge base should inform the community of their availability and willingness to participate in patient care outside of the operating room. By way of example, information has been distributed to all practitioners at Arkansas Children's Hospital concerning the experience and training of faculty anesthesiologists within the Division of Pediatric Anesthesia. This dispersal of information has improved interactions with other groups, and anesthesia services are now used in a more appropriate manner on behalf of infants and children throughout our medical center. ■

# OSHA Annual Training Questions and Answers

Physicians who were required last year to comply with OSHA's Bloodborne Pathogen Standard are now required to satisfy the annual training requirement. These answers to some common questions should help physicians comply.

## **Q. Which employees are covered under the bloodborne pathogen regulation?**

A. Any employee who might reasonably be anticipated to have occupational exposure to blood or other potentially infectious materials as defined by OSHA. Part-time, temporary and per diem employees are included.

## **Q. How does OSHA define occupational exposure?**

A. OSHA defines occupational exposure as reasonably anticipated skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious materials that may result while an employee is working.

## **Q. What does OSHA define as potentially infectious materials?**

- A.
- Blood
  - Semen
  - Vaginal secretions
  - Cerebrospinal fluids
  - Synovial fluid
  - Pleural fluid
  - Pericardial fluid
  - Peritoneal fluid
  - Amniotic fluid
  - Saliva in dental procedures
  - Any bodily fluid visibly contaminated with blood

- All body fluids when it is difficult or impossible to differentiate between fluids
- Any unfixed tissue or organ from a human (living or dead)

## **Q. What must be covered in the annual training?**

A. Physicians must:

- Review the basics covered in the original training last year
- Explain how an employee can obtain a copy of the OSHA standard and explain of its content
- Provide a general, understandable review of the epidemiology and symptoms of bloodborne diseases
- Explain the modes of transmission of bloodborne pathogens

## **Q. What must the annual training cover concerning protection in the workplace?**

A. The training must cover:

- The use and methods of engineering controls in the office and work practices specific to the office.
- The use of personal protective equipment supplied to the employee for use on the job.
- The types, use, location, handling, removal, decontamination and disposal of personal protective equipment.

## **Q. What must the annual training cover pertaining to the exposure control plan?**

A. The training must include:

- An explanation of the exposure control plan and how an employee can obtain a



written copy of the plan.

- The methods of recognizing tasks that may involve exposure to blood or other potentially infectious materials.

**Q. What other information for the employee must the training cover?**

**A.** The training must include:

- An explanation of signs, labels and color coding required by OSHA.
- Actions an employee should take and who to contact in case of an emergency or exposure incident.
- A detailed explanation of blood spill containment and blood spill decontamination procedures.
- Information on hepatitis B vaccinations provided free and on the safety, value, efficacy and methods of administration.
- Post-exposure follow-up procedures, including method of reporting, medical follow up and counseling.

**A.** Yes. A record of the annual training must be maintained for a period of three years and include:

- Dates the training took place.
- Summary of the contents of the training.
- Names and job titles of employees who attended the training.
- Name and qualifications of person(s) conducting the training session.

**Q. Do physicians have to rewrite their exposure control plan?**

**A.** No, but the exposure control plan prepared for the physician's office last year must be reviewed and updated again this year if necessary. The date that the exposure plan was reviewed should be documented.

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**Q. Must records be maintained of the annual training?**

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## LEGISLATIVE COMMITTEE TO STUDY SUPPORT FOR SALES TAX AMENDMENT

House Joint Resolution 1011 Exploratory Committee has been formed for support of a constitutional amendment benefitting the Arkansas Department of Parks and Tourism, Arkansas Game and Fish Commission, Department of Arkansas Heritage and the Keep Arkansas Beautiful Commission.

The amendment was placed on the November 1994 general election ballot by the 1993 Arkansas General Assembly and will request approval of a 1/8-percent sales tax increase, with the money going to the four agencies. Revenues generated by the increase would fund projects like acquisition of threatened wetland areas, increased protection of wildlife and other natural resources, improvements to state parks, expansion of state-owned museums and an ongoing anti-litter campaign.

State Senator Jean Edwards of Sherrill and State Representative Bobby Hogue of Jonesboro will serve as co-chairmen of the exploratory committee.

Edwards said, "This amendment will allow all Arkansans to continue to enjoy the natural beauty of our state through hunting and fishing, visiting our state parks, touring museums and other cultural facilities as well as protecting our environment. Our organization is currently reviewing possible opportunities for support of the amendment."

Edwards also explained that the amendment will allow additional development of attractions that will stimulate tourism.

"The passage of this amendment will greatly impact the local economy. As our natural resources and cultural heritage are preserved and improved, tourism will increase and continue to generate revenues for employers and local governments," he said.

If Arkansas voters approve the amendment in 1994, the measure will become effective July 1, 1995.

Hogue said, "We want all Arkansans to understand how important it is to future generations that we continue to preserve our natural resources. We will seek support from every corner of the state as we move forward with this effort."

## DUCK HUNTERS SURVEYED

Arkansas duck hunters who responded to a survey said they favor a three-segment season that runs well into January.

The Arkansas Game and Fish Commission conducted the survey to better meet the desires of hunters in the annual setting of waterfowl regulations.

The survey produced answers from 390 waterfowl hunters in 51 counties. Only 16 percent said they were happy with the season dates of the past two years, but 312 favored a three-segment season - this has been used the past two years. Only 24 wanted a two-segment season and seven favored one continuous season.

Most hunters wanted an opening date of November 20-27, but 64 percent wanted the closing date to be around January 15, and 10 percent wanted a January 10-12 closing.

On the arrangement of the three splits, the average number of days requested was 5 in November, 12.4 in December and 12.6 in January,

and this division was similar for hunters from all sections of the state. Three-fourths of the hunters wanted the season dates to include as many weekends as possible. More than half said the dates should include as many holidays as possible. And 64 percent said they would favor ending shooting each day at 1 p.m. The surveyed hunters said they preferred to hunt in flooded timber (79%), in fields (10%) and on rivers (5.4%).

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Subscriptions to Arkansas Wildlife, the Arkansas Game and Fish Commission magazine, can also be bought when ordering licenses by phone. The magazine is \$5.00 a year, which includes the popular Arkansas Wildlife calendar.

## A Look Outdoors

**SEPTEMBER 18:** Free Flyfishing Clinic, Carl Garner Visitor Center at Greers Ferry Dam, 9 a.m.-4 p.m.

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**OCTOBER 1-3:** "Becoming an Outdoorswoman" Seminar, 4-H Center, Ferndale (Pulaski Co.)

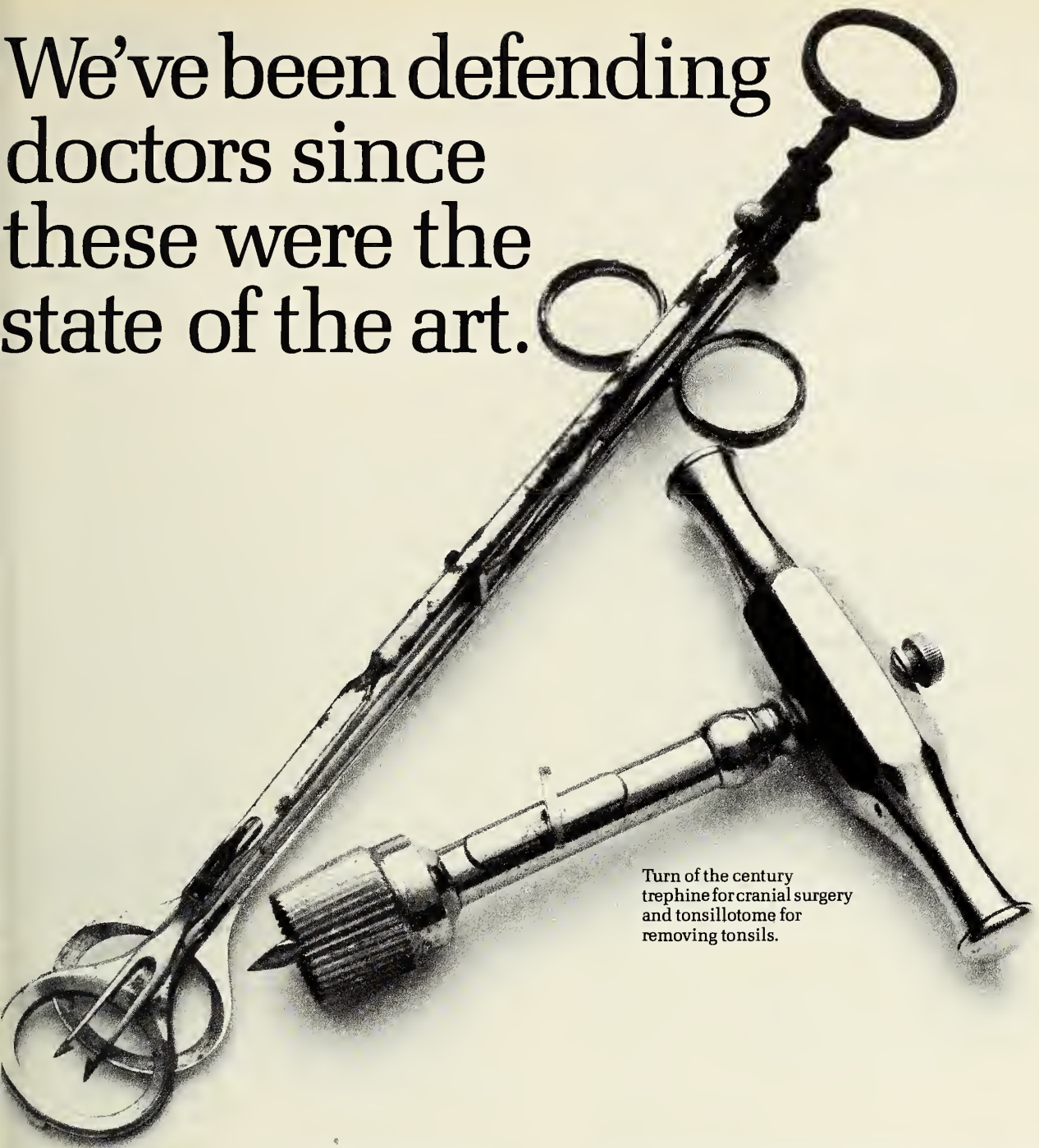
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# Tuberculosis and HIV Infection

Joseph M. Beck, II, M.D.  
Chairman, Task Force on AIDS

As the HIV epidemic continues to spread into the inner-cities and populations of color, it has had a substantial impact on the epidemiology, morbidity and mortality of tuberculosis. Long recognized as a consequence of immunosuppression, tuberculosis incidence has paralleled that of HIV infection, assuming particular importance among HIV related diseases due to its respiratory contagiousness, ready treatability, and prevention by chemoprophylaxis. Health care workers, both HIV positive and negative, are at particular risk.

By producing a progressive and profound ablation of cell mediated immunity, HIV infection increases the risk of tuberculosis through two mechanisms. Persons previously infected with tuberculosis may reactivate quiescent disease as their immune function worsens and HIV infected persons newly exposed to tuberculosis may not be able to control a new infection. Evidence discussed below suggests that active, clinical, infectious disease develops rapidly.

In New York City for example, the incidence of reported tuberculosis has increased 132% from 1980-1990. Previously, the total United States number of annual tuberculosis cases reported had declined from 84,304 in 1953 to 22,255 in 1984. Since 1984, cases nationwide have risen by 3-5% per year. In 1990, New York City reported 14% of the U.S. total of tuberculosis cases. In general the incidence of tuberculosis in persons with AIDS is 500 times that of the general population. Ninety-one percent of non-white tuberculosis patients in New York City are HIV positive.

Tuberculosis is spread by droplet contact. Active pulmonary cavitary tuberculosis poses the greatest risk with one cough estimated to produce approximately 3,000 infectious particles. Although prolonged personal contact is thought necessary to transmit infection, there are anecdotal reports of transmission through casual contact. After prolonged contact, 30% of normal hosts convert their PPD skin test to positive. Their risk of developing active clinical tuberculosis is approximately

three percent the first year, after which it diminishes rapidly; however lifetime risk is put at approximately ten percent. For the HIV positive host, 50-60% will acquire the organism through prolonged contact and the chance of developing full-blown clinical disease is 10-15% per year. In one small study of eighteen HIV infected inpatients exposed to tuberculosis seven of eighteen had active disease within 60 days of exposure to the index patient. Fifty-five percent of these patients were anergic, rendering the PPD (a negative test, at least) useless.

The standard diagnostic armamentarium for tuberculosis infection is only partially useful in those with HIV infection. In an HIV negative patient, a PPD skin test with ten millimeters of induration suggests tuberculosis infection; however, most authorities agree that in the HIV positive patient, five millimeters is sufficient to diagnose exposure. As noted above, a negative skin test does not preclude the diagnosis and the index of clinical suspicion must remain high. Placing two control skin tests is helpful in excluding anergy.

At one institution chest x-ray was suggestive of tuberculosis in 85% of patients with documented tuberculosis and HIV infection. Abnormalities included hilar adenopathy (42%), pleural effusion (29%), upper lobe infiltrates (25%), miliary pattern (13%), and cavitation (6%). Several cases were identified in which the chest x-ray was either normal or indistinguishable from pneumocystis carinii pneumonia (PCP). This has ominous significance in 1993 when inhaled pentamidine is considered standard treatment for some cases of early, mild PCP.

The chest x-ray manifestations correlated with the overall level of immunodeficiency. Patients with high levels of CD4 cells and preserved immunity were more likely to present with classic, typical x-ray findings, similar to those of non-HIV infected patients. More severely compromised patients were more likely to have miliary patterns, hilar adenopathy or extra-pul-



monary tuberculosis. Seventy percent of patients with full blown AIDS had some manifestation of extrapulmonary tuberculosis, including bacteremia, lymphadenitis, brain abscess or tuberculosis meningitis. Sputum smears are positive for AFB in 31% to 82% of cases; with bronchoscopy results being similar. Once again, the less immunocompromised the patient, the more likely smears are to be positive as in typical tuberculosis. As might be surmised, delayed diagnosis results in significant morbidity and danger of contagion. One study found that 48% of AIDS patients with tuberculosis died untreated or began therapy more than three weeks after presentation. Management errors were found in 84%.

An alarming recent development has been that of multi-drug resistant tuberculosis (MDR-TB). Although initially limited to nosocomial outbreaks, a recent study found that the proportion of isolates resistant to one or more anti-tuberculosis medications in New York City increased from 10% in 1982 to 23% in 1991. Although all drug resistance can ultimately be traced to inappropriate therapy or poor compliance. As of April 1991, most patients with MDR-TB had been initially infected with resistant organisms. Fifty-one percent of patients in this study had already received anti-tuberculosis medications, suggesting fairly ineffective current treatment and public health strategies. MDR-TB is a major nosocomial hazard to health care workers. After pro-

longed exposure, five to seven percent develop full-blown disease within two years; current cure rates for MDR-TB are only in the range 60%, the remainder die with, or of, multiple-drug resistant tuberculosis. There is some evidence that health care workers with a positive PPD initially may have some protection against acquiring MDR-TB. HIV positive care workers are particularly at risk as noted above. Below are current treatment guidelines for treatment of active tuberculosis:

1. HIV negative: INH, Rifampin for nine (9) months.
2. HIV positive: INH, 300 mgs/day, Rifampin, 600 mgs/day, Pyrazinamide, 20-30 mgs/kg/day.

All of the above for two months, then INH/Rifampin for total of nine months or six months beyond culture conversion.

3. Add Ethambutol, 25 mg/kg/day for CNS, disseminated or suspected drug resistant tuberculosis.
4. If either INH or Rifampin not in regimen, continue therapy for 18 months or 12 months after culture conversion.

HIV positive patients who convert their PPD to positive should receive at least twelve months (maybe lifetime) of INH Chemo Prophylaxis.

In conclusion, co-infection with HIV and tuberculosis is a growing problem. All HIV positive patients with respiratory symptoms or signs should be considered to have active tuberculosis until proved otherwise. This includes respiratory isolation and UV light rooms. Pulmonary tuberculosis must be ruled out in all patients prior to beginning therapy with inhaled Pentamidine. Clinics and hospitals must continue to address this problem of nosocomial transmission of tuberculosis to both health care workers and patients.

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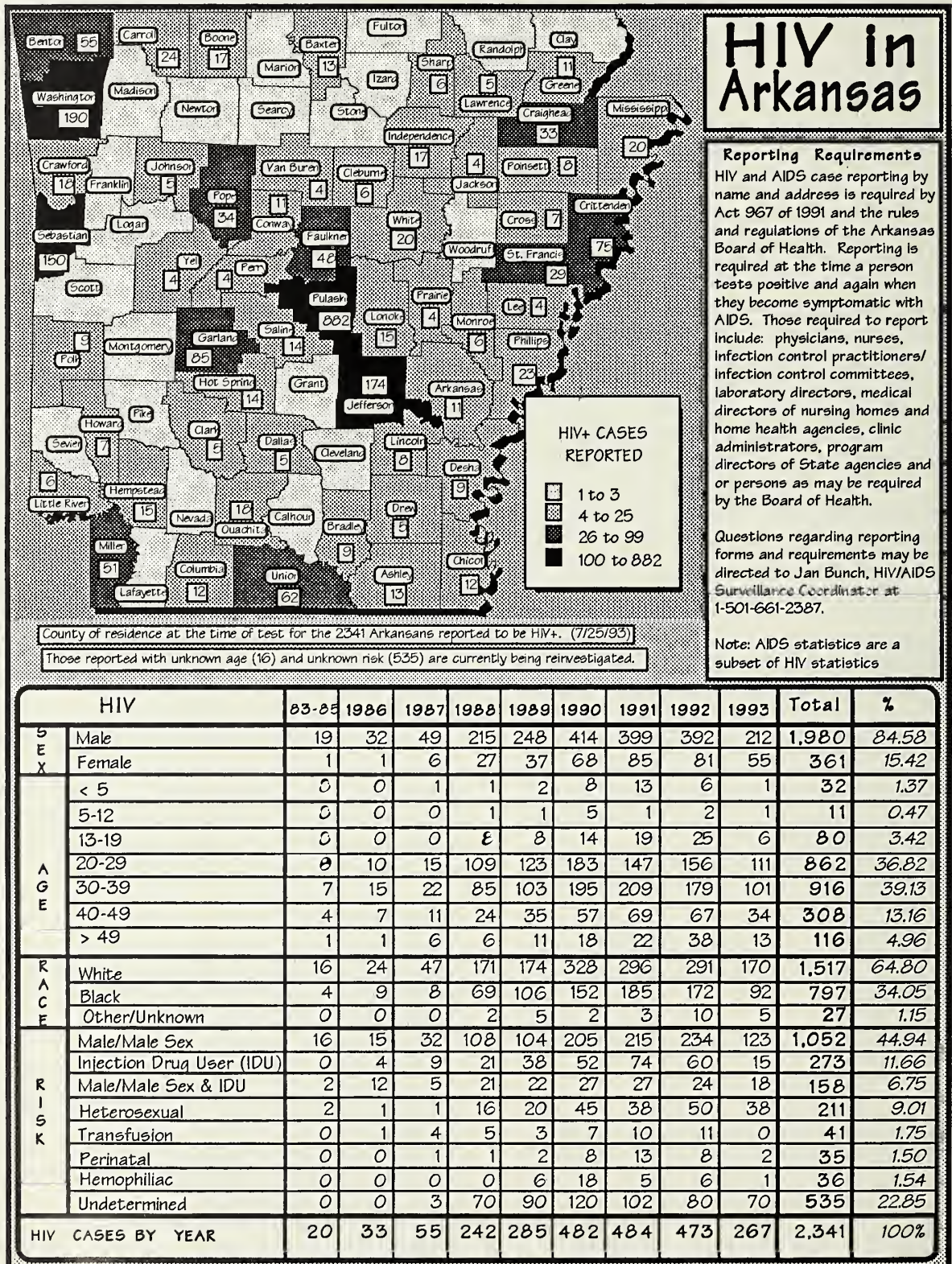
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# Arkansas HIV/AIDS Report 1983-1993

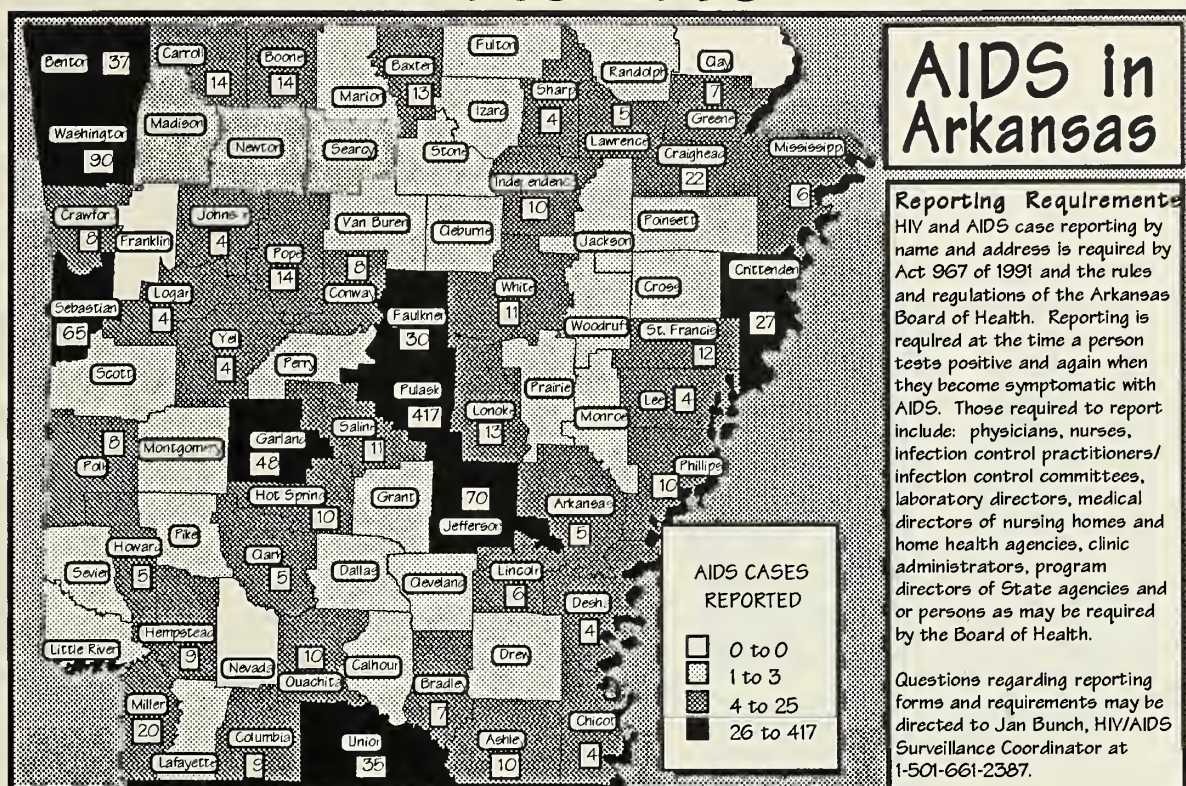


Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1993



Of the 2341 Arkansans reported to be HIV+, 1195 have been diagnosed with AIDS. (7/25/93)

AIDS		83-85	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	221	1,049	87.78
	Female	1	0	4	6	10	20	25	35	45	146	12.22
AGE	< 5	0	0	0	1	1	6	6	3	0	17	1.42
	5-12	0	0	0	1	0	1	1	0	1	4	0.33
	13-19	0	0	0	0	0	4	3	2	4	13	1.09
	20-29	7	9	15	27	24	55	57	81	68	343	28.70
	30-39	3	13	23	36	41	78	80	128	123	525	43.93
	40-49	1	6	8	10	7	35	41	52	54	214	17.91
	> 49	1	0	4	8	7	11	13	19	16	79	6.61
RACE	White	9	22	43	61	58	141	134	207	189	864	72.30
	Black	3	6	7	20	21	47	66	74	73	317	26.53
	Other/Unknown	0	0	0	2	1	2	1	4	4	14	1.17
RISK	Male/Male Sex	7	17	31	59	50	120	120	178	147	724	60.59
	Injection Drug User (IDU)	0	2	10	4	11	18	29	43	36	149	12.47
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	15	96	8.03
	Heterosexual	2	0	2	3	6	10	9	25	30	85	7.11
	Transfusion	0	0	2	7	3	7	11	3	2	35	2.93
	Perinatal	0	0	0	1	1	6	6	3	1	18	1.51
	Hemophiliac	0	0	0	1	1	5	5	4	5	21	1.76
	Undetermined	0	0	1	2	2	6	4	11	30	67	5.61
AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	266	1,195	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.





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# New Members

---

## BERRYVILLE

**Nash, John R.**, Family Practice. Medical education, Medical College of Wisconsin, Milwaukee, 1984. Internship, E.A. Conway Memorial Hospital, Monroe, Louisiana, 1985. Residency, AHEC, Fort Smith, 1987. Board certified.

## EUREKA SPRINGS

**McAlister, Robin J.**, Family Practice. Medical education, UAMS, 1990. Internship/Residency, AHEC-Northwest, Fayetteville, 1993. Board certification pending.

## FORT SMITH

**Flanagan, Alan D.**, General Surgery. Medical education, University of Florida, Gainesville, 1986. Internship, Indiana University, 1987. Residency, Michigan State University, 1993.

**McCarthy, Joseph P.**, Child Neurology. Medical education, UAMS, 1976. Internship, William Beaumont Army Medical Center, El Paso, Texas, 1977. Residency, Walter Reed AMC, Washington, D.C., 1982. Board certified.

**Teeter, Mark D.**, Anesthesiology. Medical education, UAMS, 1988. Internship, The Medical Center, Columbus, Georgia, 1989. Residency, University Medical Center, Jackson, Mississippi, 1992. Board certified.

**Whitaker, John C.**, Pediatrics. Medical education, UAMS, 1986. Internship, UAMS, 1987. Residency, UAMS-Arkansas Children's Hospital, 1989. Board certified.

## HARRISON

**Collins, Kenneth P.**, Family Practice. Medical education, University of South Alabama College of Medicine, Mobile, 1981. Internship, University of South Alabama College of Medicine, 1982. Residency/Fellowship, Baptist Medical Center, Birmingham, Alabama, 1986. Board certified.

## HOT SPRINGS

**Carpenter, James B.**, General Practice - Geriatrics. Medical education, Indiana University Medical School, Indianapolis, 1955. Internship, Riverside, California, 1956.

**Hughes, James A.**, Pediatrics. Medical education, UAMS, 1987. Internship/Residency, Arkansas Children's Hospital, 1990. Board certified.

## JONESBORO

**Casey, Jason R.**, Internal Medicine. Medical education, UAMS, 1989. Internship/Residency, UAMS 1992. Board certified.

**Stidman, Jeffrey S.**, Gastroenterology. Medical education, UAMS, 1988. Internship/Residency, University Hospital and John McClellan Veterans Administration Hospital, 1991. Fellowship, University of Tennessee Medical Center, 1993. Board certified.

## LITTLE ROCK

**Brady, Mark**, Family Practice. Medical education, UAMS, 1990. Internship/Residency, Cox Medical Center, Springfield, Missouri, 1993. Board eligible.

**Edwards, Peter M.**, Psychiatry. Medical education, University of Kansas, 1988. Internship/Residency, UAMS, 1992.

**Greer, Christopher A.**, Ophthalmology. Medical education, University of Osteopathic Medicine & Sciences, Des Moines, Iowa, 1984. Internship/Residency, Botsford General Hospital, Farmington Hills, Michigan, 1988. Board certified.

**Herbert, Ralph W.**, Pediatrics. Medical education, University of Mississippi Medical School, Jackson, 1976. Internship/Residency, UAMS, 1980. Fellowship, Southwestern Medical School, Dallas, 1982.

**Hill, Joy Wilson**, Pediatrics. Medical education, University of North Carolina, Chapel Hill, 1990. Internship/Residency, UAMS/Arkansas Children's Hospital, 1993.

**Kelly, Karen Young**, Pediatrics. Medical education, UAMS, 1988. Internship/Residency, University of South Florida, Tampa, 1991. Board certified.

**Krebel, Steven R.**, Pediatrics. Medical education, University of Texas Southwestern Medical School, Dallas, 1988. Internship/Residency, Arkansas Children's Hospital/UAMS, 1991. Board certified.

**Montgomery, Lori E.**, Pediatrics. Medical education, UAMS, 1989. Internship/Residency, Arkansas Children's Hospital/UAMS, 1993. Board certified.

**Norris, Lloyd P.**, Cardiovascular Disease. Medical education, UAMS, 1986. Internship/Residency, University of Alabama, Birmingham and University of Texas Health Science, San Antonio, 1993. Board certified.

**Ross, Robin L.**, Psychiatry. Medical education, UAMS, 1985. Internship, UAMS, 1986. Residency, UMDNJ, Newark, New Jersey and Georgetown, Washington, D.C., 1990. Board certified.

**Sloan, Gene**, Plastic & Reconstructive Surgery. Medical education, UAMS, 1985. Internship, UAMS, 1986. Residency, Columbia, Missouri and Miami, Florida, 1993.

**Tahiri, Abdalla A.**, Gastroenterology. Medical education, UAMS, 1988. Internship/Residency, UAMS, 1993. Board eligible.

**Washington, Mitzi A.**, Pediatrics/Internal Medicine. Medical education, UAMS, 1989. Internship/Residency, UAMS, 1993.

**Williams, Paul E.**, Gastroenterology. Medical education, UAMS, 1987. Internship/Residency, UAMS, 1990. Board certified.

## MOUNTAIN HOME

**McAlister, Matthew K.**, Radiology. Medical education, UAMS, 1988. Internship, Hennepin County Medical Center, Minneapolis, 1989. Residency, University of Minnesota, Minneapolis, 1993. Board certified.

**Robbins, Bruce D.**, Neurology. Medical education, University of Utah, Salt Lake City, 1980. Internship, Denver, Colorado, 1981. Residency, Iowa City, Iowa and Indianapolis, Indiana, 1990. Board certified.

## NORTH LITTLE ROCK

**Brooks, David W.**, Physical Medicine and Rehabilitation. Medical education, UAMS, 1989. Internship/Residency, UAMS, 1990. Board eligible.

**Metzer, W. Steven**, Neurology. Medical education, UAMS, 1976. Internship/Residency, UAMS, 1982. Board certified.

## PINE BLUFF

**Campbell, James A., Jr.**, Nephrology. Medical education, Meharry Medical College, Nashville, Tennessee, 1982. Internship/Residency, Henry Ford Hospital, Detroit, Michigan, 1985. Board certified.

## SPRINGDALE

**Haws, Karl W.**, Family Practice. Medical education, Oklahoma State University of Osteopathic Medicine, Tulsa, 1990. Internship, Still Regional Medical Center, Jefferson City, Missouri, 1991. Residency, Fayetteville Family Practice, 1993. Board eligible.

**Oates, Randall B.**, Family Practice. Medical education, UAMS, 1981. Residency, AHEC-Northwest, Fayetteville, 1984. Board certified.

## RESIDENTS

**Adkisson, Jarrod**, Psychiatry. Medical education, UAMS, 1993.

**Allison, Russell**. Medical education, UAMS, 1993.

**Baldwin, Shelly**, Pediatrics. Medical education, UAMS, 1993.

**Beckel, Ron, Jr.**, Pediatrics. Medical education, UAMS, 1993.

**Bishop, Kellie**, Neurology. Medical education, UAMS, 1993.

**Boren, Edwin L., Jr.**, Radiology. Medical education, UAMS, 1993.

**Calicott, Timothy**, Emergency Medicine. Medical education, UAMS, 1993.

**Cash, J. Steven**. Medical education, UAMS, 1993.

**Clary, Cathy**, Family Practice. Medical education, UAMS, 1993.

**Delap, Susan**. Medical education, UAMS, 1993.

**Dopp, Patrick**, Internal Medicine. Medical education, UAMS, 1993.

**Ebsen, Tammy**, Anesthesiology. Medical education, UAMS, 1993.

**Emery, Robert**, Urology. Medical education, UAMS, 1993.

**Evyan, Michele**, Family Practice. Medical education, UAMS, 1993.

**Fox, Robert, Jr.**, Family Practice. Medical education, UAMS, 1993.

**Froman, Elizabeth A.**, Pediatrics. Medical education, UAMS, 1993.

**Hagaman, Michael S.**, Family Practice. Medical education, UAMS, 1992. Internship/Residency, John Peter Smith.

**Hays, David A.**, Diagnostic Radiology. Medical education, UAMS, 1993.

**Henry, William, Jr.**, Family Practice. Medical education, UAMS, 1993.

**Hill, Shanna**, Family Practice. Medical education, UAMS, 1993.

**Keating, Janice**. Medical education, UAMS, 1993. Residency, University of Alabama, Birmingham.

**Martin, Linda J.**, Psychiatry. Medical education, UAMS, 1990. Internship/Residency, UAMS, 1993.

**Massanelli, Gregg**, Orthopaedics. Medical education, UAMS, 1993.

**McClain, Tina**, Psychiatry. Medical education, UAMS, 1993.

**Nutt, Angela**, Internal Medicine. Medical education, UAMS, 1993.

**Pankiewicz, Irena**, Neurology. Medical education, Pomorska Akademia Medyczna Im. Gen. K. Swierczewskiego, Szczecin, Poland, 1985. Internship/Residency, UAMS.

**Parish, Barton**, Family Practice. Medical education, UAMS, 1993. Residency, AHEC, El Dorado.

**Price, John G.**, Internal Medicine. Medical education, UAMS, 1993.

**Price, Kevin S.**, Psychiatry. Medical education, UAMS, 1991. Internship/Residency, Baylor College of Medicine, Houston, Texas.

**Stout, Paul**, Radiology. Medical education, UAMS, 1993.



**Verser, Michael**, Family Practice. Medical education, UAMS, 1993.

**Walker, Shannon**, Radiology. Medical education, UAMS, 1993.

**Ward, Susan**, Internal Medicine. Medical education, UAMS, 1993.

**Wilbourn, Darin**, Anesthesiology. Medical education, UAMS, 1993.

**Wilkins, James**, Pediatrics. Medical education, UAMS, 1993.

## STUDENTS

Christopher M. Albertson

Nancy K. Anderson

James R. Arnold

Michelle J. Banning

William G. Byrd

Kimberly L. Cadle

David W. Cole

William A. Dulin

R. Scott Fisher

John L. Furlow

Stacy H. Furlow

James J. Goad

Bernadette A. Gunther

Melanie D. Hoover

Christopher M. Hults

John D. Hungarland

Jeffrey D. Kellar

Carol L. Johnston

James S. Lewis, Jr.

Ivy V. McGee-Reed

Brian E. Meyer

Michael Nolen

Emmanuel C. Nwokedi

James M. Orender

Paul H. Pappas

Pui Fun W. Pappas

Sonya A. Peppers

Lisa M. Petursson

Melissa N. Quevillon

Lonnie S. Robinson

John P. Scurlock

Huda F. Sharaf

Mai F. Sharaf

Kristin L. Steingraber

John S. Stockburger

Shannon R. Turner

Laura L. Ward

## In Remembrance of Dewey Lantrip

Dewey Lantrip, of Little Rock, died Wednesday, August 4, 1993. He was 84.

He actively served on the Arkansas State Medical Board from his first appointment by then Governor Bill Clinton in 1983 until his death. He was appointed as a senior citizen representative. In the words of Arkansas State Medical Board Chairman Dr. Ray Jouett, "his service to the state has been exemplary and his contribution has been outstanding."

Among his other achievements, he served as AARP State Health Care Coordinator for 3 years, AARP State Legislative Committee Chairman and has received numerous awards including the Shuffield Award by the Arkansas Medical Society.

He was the widower of Velah Fern Lantrip. His survivors are three daughters, Zolabel Greenfield of Festus, Mo., Jacklenel Hurd and Sarah Kay Lantrip, both of Little Rock; one sister, Lala Wright of Coy, Ark.; two brothers, Hubert Lantrip of Lonoke and Wayne Lantrip of Zachary, La.; one half-sister, Lois Roncal of Tyler, Texas; 4 grandchildren; and 3 great-grandchildren.

## In Memoriam

### Oscar Kozberg, M.D.

Dr. Oscar Kozberg, of Little Rock, died Monday, August 2, 1993. He was 84.

Survivors are two sons, Steven A. Kozberg of Little Rock and Bernard H. Kozberg of Minneapolis; two brothers, Sam Kozberg and Norman Kozberg, both of St. Paul, Minnesota; and two sisters, Ruth Bresslermann and Margaret Lovich, both of St. Paul, Minnesota.

### Claudia Evelyn Howard McMillin

Claudia Evelyn Howard McMillin, of Little Rock, died Monday, August 2, 1993. She was 78.

Survivors are her husband, Dr. F. Lamar McMillin, Sr.; her son, Dr. F. Lamar McMillin, Jr.; her daughter-in-law, Carol; and three grandchildren, Ashley, David and Stephen McMillin, all of Vicksburg, Miss.; one sister, Marguerite Howard Von Segen, and one brother, Robert Eugene Howard, both of North Little Rock.

### William Troy Raney, Sr., M.D.

Dr. William Troy Raney, Sr., of Cave City, died Wednesday, July 7, 1993. He was 82.

Survivors include his wife, Ada Bittle Raney; four sons, William Troy Raney, Jr. and Charles W. Raney, both of Sacramento, California, Daryl G. Raney of Colorado Springs, Colorado, and Myron K. Raney of Little Rock; four daughters, Cheryl Raney Roth and Sandra M. Abreu, both of Sacramento, California, and Bonnie G. Miller and Jo Anne Wilkes, both of Cave City; two brothers, Glenn Raney of Sacramento, California, and the Rev. Owen Raney of Springfield, Missouri; a sister, Ola Mae Williams of Sacramento, California; and 10 grandchildren.



# Medical Student Reception

The Arkansas Medical Society hosted a "Welcome to UAMS" reception for first year medical students and their spouses/guests on Thursday, April 5 at Pavilion in the Park. The reception was the final event of "Orientation Week" and was attended by AMS officers and UAMS Faculty.

After listening to music by guitarist Steve Guthrie, door prizes were awarded to the following students:

Krystyna Kozlowski	Smitty's gift certificate
Stacy Furlow	Juanita's gift certificate
Huda Sharaf	Blue Mesa gift certificate
Dennis Blake	Cajun's Wharf gift certificate
Matt McLellan	Movie passes
Bernie Gunther	Beach towel
John Harris	Beach towel
Blake Sayre	Athletic bag
George Lawrence	Athletic bag
Julie Wilmot	Athletic bag
David Cole	Umbrella

The reception was co-sponsored by the UAMS Parent's Club, the Caduceus Club and First Commercial Bank.







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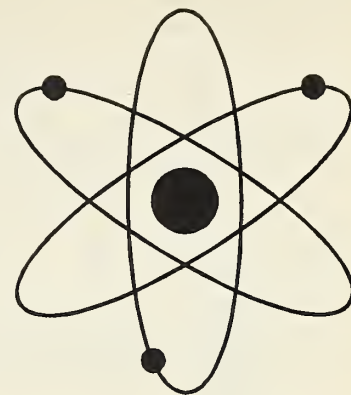
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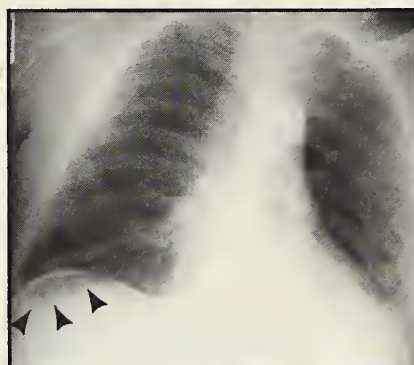
# Radiological Case of the Month



David L. Harshfield, M.D.  
Kelly G. Grigg, B.S.

## History:

This patient is a 73-year-old male who presented with acute right upper quadrant pain three days post carotid endarterectomy. An acute abdomen series was performed.



*Figure 1: Above.  
Figure 2: Right top.  
Figure 3: Right.*

---

# Free intraperitoneal air.

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## Findings:

The patient's supine abdominal film did not reveal evidence of intra-abdominal problem (Figure 1), however, the PA chest film (Figure 2) had a suspicious air collection (black arrows) under the right hemidiaphragm. The left lateral decubitus film (Figure 3) reveals air (white arrows) between the lateral border of the liver and abdominal wall.

## Discussion:

In order to evaluate for the presence of free intraperitoneal air, the patient was placed in a left lateral decubitus position and, after approximately 10 minutes, a film of the abdomen was obtained with the x-ray beam centered over the liver. While the patient was positioned left side down, the intraperitoneal air migrated to his right upper quadrant and was readily observed interposed between the parietal peritoneum and the liver. The patient was sent to surgery and was found to have a perforated duodenal ulcer.

Any time a patient is suspected of having free intraperitoneal air that is not seen on the standard views of an acute abdomen series, this maneuver will reveal even small amounts (1 to 3 cc's) of air when present.

## Bibliography:

Mindelzum RE and McCort JJ. In: Margulis AR and Burhenne HJ. (editors) Alimentary Tract Radiology. Third Edition. St. Louis: The C.V. Mosby Company, 1983, pp 391-397.

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*Editor: Dr. David Harshfield is chief of the radiology service at the Veterans Administration Hospital in Little Rock, and director of radiology at Riverside Radiologist Group in North Little Rock.*

*Contributor: Kelly Grigg is a premedical student research assistant at the University of Arkansas for Medical Sciences in Little Rock.*



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**Dr. Robert W. Barnes**, a vascular surgeon and chairman of the UAMS Department of Surgery, and **Dr. John F. Redman**, professor and chairman of the Department of Urology and professor of pediatrics at UAMS, are this year's recipients of the Distinguished Faculty Award from the College of Medicine at the University of Arkansas for Medical Sciences.

**Dr. Roger Bost**, retired Little Rock pediatrician, recently received the 1993 Chancellor's Award from the University of Arkansas for Medical Sciences. This award is given to physicians who have dedicated their lives to the betterment of their community and their medical field.

**Dr. Owen H. Clopton**, of Jonesboro, a specialist in internal medicine, has been appointed to the Arkansas State Medical Board. Clopton replaces Dr. Asa A. Crow of Paragould, who recently resigned.

**Dr. Cole Goodman**, of Plastic Surgery Specialists in Fort Smith, has been elected to a three-year term as treasurer of the Southeastern Society of Plastic and Reconstructive Surgeons.

He is the founder and a past president of the Arkansas Society of Plastic and Reconstructive Surgeons. He is also president of the Arkansas Hand Surgery Society.

## Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of May, June and July are:

Leslie Fay Anderson	Lonoke	John A. Huskins	Rogers
James Douglas Armstrong	Ashdown	Stacey M. Johnson	Mountain Home
H.A. Ted Bailey	Little Rock	Kenneth B. Jones	Jonesboro
Jeffrey Liston Barber	Little Rock	John W. Joyce	Little Rock
Lawrence Frank Braden	Camden	Byron L. Lam	Little Rock
Joseph Kimball Buchman	Little Rock	Robert H. Langston	Harrison
Joe Lee Buford	North Little Rock	Paula M. Lynch	Little Rock
Thomas Darrell Cain	Little Rock	Stephen K. Magie	Conway
Richard Allen Calhoun	Little Rock	William R. McKiever	Monticello
James W. Campbell	Hot Springs	George O. Paddock	Jacksonville
Joe Barrett Colclasure	Little Rock	Fernando Padilla	Little Rock
Steven F. Collier	Augusta	James J. Pappas	Little Rock
John R. E. Dickins	Little Rock	Dac Tat Pham	Brinkley
Marlon J. Doucet	Little Rock	Carl J. Raque	Little Rock
Stevenson Flanigan	Little Rock	William V. Relyea	Cherokee Village
Robert Douglas Foster	Mountain Home	Kenneth V. Robbins	Little Rock
Clinton James Fuller	Little Rock	Franklin D. Roberts	Magnolia
Joseph Miller Gettys	Little Rock	Leonus L. Shedd	Paragould
Curtis Don Greenway	Little Rock	Joseph F. Shotts	Cabot
Benjamin H. Hall	Lincoln	Charles P. Sisco	Springdale
Larry Leon Hanley	Fort Smith	Scott G. Stinnett	Siloam Springs
Philip Raymond Hardin	Mountain Home	Alan R. Storeygard	Jacksonville
William F. Hefley	Little Rock	Ronald C. Walker	Little Rock
Kathryn D. Hendrickson	Fort Smith	James R. Weber	Jacksonville
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# Medicine in the News

## Health Care Access Foundation Update

As of August 1, 1993, the Arkansas Health Care Access Foundation has provided free medical service to 6,244 medically indigent persons, received 6,808 applications, and enrolled 12,788 persons.

The program has 1,638 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

## Physician Survey to be Mailed in September

The Arkansas Office of Rural Health and the Office of Primary Care will be conducting a survey of physicians licensed in the state in order to establish an accurate shortage designation of primary care providers practicing in Arkansas. In addition to assisting with statewide health care planning activities, without accurate data, the state can lose out on valuable federal and private foundation grants to improve health care access in rural and underserved communities. When you receive the survey, we hope you will promptly answer the questions and return it to the Office of Rural Health. They survey will be mailed to both primary care physicians and specialists. For additional information contact Linda Goldsmith, Director, Office of Rural Health, 661-2375.

## Practice Parameters Available on CD-ROM

*Practice Parameters on CD-ROM, 1993 Edition*, is available from the AMA's Office of Quality Assurance and Medical Review.

This new product offers physicians the ability to instantly and conveniently access full text parameters. It includes more than 250 parameters from more than 20 physician organizations.

Updates will be sent automatically throughout 1993 to purchasers, ensuring they receive current parameter additions and deletions.

Call (800) 621-8335 to order the single user version, ask for item #OP270493CU; network version item number is #OP270693CU.

## DEA Registration Fee Increase Results in Confusion and Litigation

The Drug Enforcement Administration (DEA) recently increased registration fees for those who manufacture, distribute, prescribe, or dispense controlled substances from \$60 to \$210. The stated purpose of the increase was to fund a drug Diversion Control Program.

The DEA then sent out approximately 30,000 controlled substances registration certificates incorrectly stating that a \$60 registration fee was paid instead of the \$210 fee. Physicians who received the incorrect certificates do not need to take action. A corrected form will soon be issued.

However, the AMA and four other medical and pharmaceutical groups have recently filed a lawsuit challenging the DEA fee increases.

While supportive of the DEA's effort to stop the illegal diversion of controlled substances and mindful that physicians are willing to assist in this effort, the lawsuit contends that the final rule issued by the DEA is not an act of reasonable government and does not comply with federal law.

The lawsuit alleges that nowhere in the final rule did the DEA:

- Define the nature, scope, and operations of the Diversion Control Program;
- Explain the relationship, if any, between the Diversion Control Program and the activities of those required to pay registration fees;
- Justify the large increase in registration fees designed to support the Diversion Control Program; or
- Justify the DEA's allocation of these fees among the various categories of registrants.

## AMA Questions Confidentiality of Data Bank "Self-queries"

The AMA has requested the federal government to look more closely at the regulations protecting the confidentiality of the information contained in the National Practitioner Data Bank. The Office of General Counsel of the Department of Health and Human Services has agreed to respond to the AMA's request.

The National Practitioner Data Bank, created in 1986 by the Health Care Quality Improvement Act, contains information related to licensure actions, clinical privilege actions, and society membership actions as related to the professional conduct and competence of physicians, as well as information regarding payment of medical malpractice claims. Federal law dictates who may query and use the information contained in the Data Bank: health care entities that (1) provide health care services, and (2) engage in formal peer review. Physicians may also self-query their files.

The AMA has long been concerned that unauthorized entities, especially managed care plans and some medical liability insurers, have been circumventing their inability to query the Data Bank. These unauthorized entities require a physician to obtain a copy of his



or her own Data Bank report and submit the report to them.

It is presently unclear whether, under federal law, Data Bank reports that are "rediscovered" by physicians or unauthorized entities maintain confidentiality under the law of the highly sensitive material contained in the Data Bank.

Until a formal response is received from DHHS, the AMA recommends that physicians who release Data Bank information to unauthorized entities require such entities to provide them with the following written documentation:

That the requirement that the physician self-query the Data Bank and disclose the information to the entity is in compliance with the intent and protections of the Health Care Quality Improvement Act;

That the information disclosed to the entity will be protected from further disclosure under the relevant state peer review immunity statute(s);

That the information will be used for and maintained only for those purposes, such as quality review activities, that are protected under the relevant state peer review immunity statute(s);

That the entity will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act.

Federal law does not prohibit entities from redisclosing Data Bank reports if "authorized by state law". As it is unclear how this exception to the confidentiality provisions will be interpreted, physicians should submit Data Bank reports only to entities that are prohibited, generally under state peer review laws, from further redisclosing the information.

### **Nominations Being Accepted for the 1994 John P. McGovern *Compleat* Physician Award**

The Houston Academy of Medicine has announced a call for nominations for the 1994 John P. McGovern *Compleat* Physician Award.

The award, named after its first recipient, consists of a medallion and \$5,000 and will be presented to the recipient in January 1994 at the Annual Meeting of the Houston Academy of Medicine in Houston, Texas. The award is national in scope and is open to all licensed physicians. Nominations must be received by November 1, 1993.

The purpose of the award is to bestow recognition on a physician who has made extraordinary contributions to medicine and humanity, and to remind physicians everywhere they have unique opportunities to serve mankind.

Complete information, rules and an official nomination form may be obtained by writing the Houston Academy of Medicine, Jesse H. Jones Library Building, 133 M.D. Anderson Boulevard, Texas Medical Center, Houston, Texas 77030.

### **Call for Papers**

The International Conference on Physician Health, to be held September 14-18, 1994 in Ottawa, Ontario, Canada is accepting abstracts addressing topics related to physician health, including AIDS, HIV, problems related to aging, mental illness, substance abuse, and physical disabilities and limitations, including those caused by general medical conditions. Possible topics for presentation include: presentation and treatment of health problems among physicians, the impact of disorders on physicians' families and practices, medical-legal issues facing hospital administrations and licensing boards, and material on health promotion and disease prevention. Abstracts which address issues related to these topics (i.e., prevention, diagnosis, treatment, rehabilitation), but not dealing specifically with physicians are also welcome. Submission Deadline: February 1, 1994. Contact Elaine M. Tejcek, Department of Mental Health, American Medical Association, 515 N. State Street, Chicago, IL 60610, (312) 464-5073.

**OKLAHOMA, Oklahoma City:** Medical Director, Full-time, and Part-time Staff Positions available at this Level II Trauma Center with approximately 32,000 annual patient visits. Attractive compensation package in excess of \$200,000 annually. Professional liability insurance is procured through EmCare. Excellent health, life, disability package available for full-time independent contractors. Send Curriculum Vitae or contact Ryan Tedrow at EmCare, Inc., 1717 Main St., Ste. 5200, Dallas, Texas 75201; (800) 527-2145 or (214) 712-2000.

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# Things To Come

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## October 1

**Recertification: New Evaluation Methods and Implementation Strategies.** Chicago Marriott Hotel O'Hare, Chicago, Illinois. Registration fee: \$235. For more information, call (708) 491-9091.

## October 1-2

**Physician Executive Leadership.** Washington University Medical Center, St. Louis, Missouri. Sponsored by the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

## October 1-3

**International Liver Symposium.** Marriott Crystal Gateway Hotel, Arlington, Virginia. For more information, contact Daniel E. Reichard, George Washington University Medical Center, Office of CME, Washington, DC, (202) 994-4285.

## October 2-3

**Ultrasound Update: 1993.** Red Lion Inn, Sacramento, California. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Category I credit: 10 hours. For more information, call (916) 734-5390.

## October 6-14

**Sixth Biennial Allergy Abroad Seminar.** Holland and Belgium. For more information, contact Phillip E. Korenblat, M.D. at Washington University Medical Center in St. Louis, Office of Continuing Medical Education, (314) 362-6893 or (800) 325-9862.

## October 15-20

**1993 Utilization Management Conference/1993 Annual Managed Care Conference & Exhibition.** Disney's Contemporary Resort, Orlando, Florida. Sponsored by the American Managed Care and Review Association. For more information, call (202) 728-0506.

## October 16

**General Medicine Update for the Ophthalmologist.** Cancer Center Auditorium, UC Davis Medical Center, Sacramento, California. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Approximately 6 hours Category I. For more information, call (916) 734-5390.

## October 17-20

**Annual Managed Care Conference & Exhibition.** Disney's Contemporary Resort, Lake Buena Vista (Orlando), Florida. CME credit offered. For more information, call (202) 728-0506.

## October 21-22

**Managed Care in the 90s.** Hyatt Newporter, Newport Beach, California. Presented by the National Association of Managed Care Physicians. An interactive forum on all aspects of managed care. For more information, call Laura Russell, (800) 722-0376.

## October 21-23

**Traumatic Brain Injury: 1993.** Hilton Inn, Sacramento, California. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Tuition: \$475, physicians; \$375, others. Category I credit: 22 hours. For more information, call (916) 734-5390.

## October 27-28

**How to Plan and Implement a Total Quality Improvement Program for Your Hospital: The Tested 7-Step TQI System to Achieve Quantum Leaps in Efficiency, Speed and Quality.** Ritz Carlton, Houston. For more information, call QualityAlert Institute, at (800) 221-2114.

## October 28-31

**87th Annual Scientific Assembly of the Southern Medical Association.** New Orleans, Louisiana. Fee: \$75 member; \$200 non-member. AMA, AAFP, AOA offered - hours to be announced. For more information, call SMA Registration Department (205) 945-1840, (800) 423-4992 or FAX (205) 942-0642.

**MISSOURI: GASTROENTEROLOGIST** - Seeking second BC/BE gastroenterologist to join busy, well-established gastroenterology practice in growing, picturesque midwestern town of 10,000 serving an area of 75,000. Located 40 minutes west of St. Louis, Missouri. Office endoscopy facilities available. Affiliation with excellent community hospital with excellent GI laboratory facilities. Interested applicants should send CV to Eugene Tucker, MD, FACG, FACP, 800 East Fifth Street, Suite 212, Washington, MO 63090.



**October 29**

**Frontiers in Ovulation Induction.** Teaneck, New Jersey. Sponsored by the Office of CME, Washington University School of Medicine. For more information, call (800) 325-9862.

**November 3**

**4th Annual Rush Symposium on Transplantation.** Rush-Presbyterian-St. Luke's Medical Center. Fee: \$100 and \$75 for fellows and post-doctoral students. For more information, call (312) 942-6242.

**November 4-7**

**12th Annual Scientific Meeting of the American Pain Society.** Buena Vista Palace, Orlando, Florida. For further information, contact Cynthia Porter at The American Pain Society, (708) 966-5595.

**November 5-7**

**Fifth Annual Infectious Disease Review Course for the Practicing Physician.** Hyatt Regency Bethesda, Maryland. Sponsored by the Center for Bio-Medical Communication. Category I credit: 17.5 hours. For more information, call (201) 385-8080 or (800) 231-0389.

**November 11-14**

**40th Annual Meeting of the Academy of Psychosomatic Medicine.** The Fairmont Hotel, New Orleans. For more information, call (312) 784-2025.

**November 12-14**

**Anesthesiology Update: 1993.** Monterey Plaza Hotel, Monterey, California. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine and Medical Center. Category I credit: 14 hours. For more information, call (916) 734-5390.

**November 13**

**Updated Neurology for the Primary Care Physician.** UC Davis Medical Center, Cancer Center Auditorium, Sacramento, California. Sponsored by Office of CME. Approximately 8 hours Category I credit. For more information, call (916) 734-5390.

**November 14-18**

**97th Annual Meeting of The American Academy of Ophthalmology.** McCormick Place, Chicago. For more information, call The American Academy of Ophthalmology Meeting Department at (415) 561-8500.

**November 19-20**

**3rd Annual Pain Management Conference.** Silverado Country Club, Napa, California. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For information, call (916) 734-5390.

# YOCON® YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

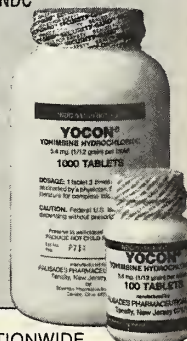
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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## Update in Primary Care Geriatrics - 3 Part Series

September 11, October 30 & November 13, Baker Conference Center, Washington Regional Medical Center. This conference, sponsored by Washington Regional Medical Center, will be divided into 3 sessions to be held on the Saturday of each Razorback football home game in Fayetteville. Continental breakfast will be served. Fee: \$15. R.S.V.P. by calling the continuing medical education department at 442-1823. Category I credit: 2 hours per session.

## Mental Health Conference:

### Sexual Abuse: Signs, Symptoms and Treatment Options

September 17, 12:00 noon-1:00 p.m., Dunkerton Room, Center for Health Education, St. Vincent Infirmary Medical Center. Sponsored by Office of Continuing Education, St. Vincent Infirmary Medical Center and RESTORE and presented by Karen Boyd Worley, Ph.D. One hour Category I credit. Lunch provided. No fee, but registration required. Call RESTORE, 660-2810.

## The Impact of AIDS on Minorities in Arkansas

September 25, 9:00 a.m.-4:30 p.m., ED II Building, UAMS. Sponsored by American Red Cross, Arkansas Department of Health, Delta Region AIDS Education and Training Center (UAMS), Veterans Administration AIDS Program. Fee: \$10 (lunch and parking included); 6 CEU. For more information, call 686-5585.

## Nutrition & Aging IX: Vitamins and Minerals in Health Disease

September 29, 8:00-8:30 a.m. registration, Excelsior Hotel, Little Rock. Sponsored by UAMS College of Medicine and presented by Ronnie Chernoff, Ph.D. and David Lipschitz, M.D., Ph.D. Registration fee: \$165; VA employees: \$75.

## Ten Year Genetics Conference

October 14 & 15, 8:00 a.m.-4:15 p.m., Arkansas Children's Hospital, Brandon Conference Center. Presented by Chris Cuniff, M.D. Category I credit offered: 6.5 hours. For more information, please call Kristi Pace at 320-1248.

## Primary Care Update 1993

October 22, registration at 7:30 a.m., will adjourn at 4:45 p.m., Baptist Medical Center, J.A. Gilbreath Conference Center, Little Rock. Presented by Baptist Medical Center, Medical Affairs. Category I credit: 6 hours. Registration fee: \$90 for physicians; \$40 for nurses and other medical personnel before October 8. After October 8, \$115 - physicians; \$50 - others.

## Tenth Annual Conference on Perinatal Care

November 4-5, time to be announced, Excelsior Hotel Little Rock. Sponsored by UAMS College of Medicine and presented by Dr. J. Gerald Quirk. Category I credit to be announced.

## Surgery for Cleft Lip and Cleft Palate

November 18-21, time to be announced, Arkansas Children's Hospital Conference Center, Little Rock. Sponsored by UAMS College of Medicine and presented by Dr. Robert Seibert. Category I credit offered: 17.2 hours.

## Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

### FAYETTEVILLE-VA MEDICAL CENTER

Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

### HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, Sept. 24, Oct. 8 & 22, Nov. 12, 12:30 p.m., AMI Ozark - Quapaw Room



## **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar*, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
*Genetics Conference*, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
*Infectious Disease Conference*, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
*Pediatric Grand Rounds*, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
*Pediatric Neuroscience Conference*, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
*Pediatric Pharmacology Conference*, 5th Wednesday, 12:00 noon, 2nd Classroom  
*Pediatric Research Conference*, 1st Thursday, 12:00 noon, 2nd Floor Classroom

## **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
*Journal Club*, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Chest Conference*, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon, CARTI Auditorium. Lunch provided.  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Hematology-Oncology Conference*, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Cancer Center Team Conference*, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

## **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*Breast Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*GI Conference*, 4th Friday, 11:30 a.m., Conference Room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

## **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Chest & Problems Case Conference*, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Medicine Conference*, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Surgery Conference*, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*X-ray Case Conference*, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room

*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GRECC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institut  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

#### **EL DORADO-AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas



*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

#### **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

#### **FORT SMITH-AHEC**

*Advances in Plastic Surgery*, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Tuesdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center

#### **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Harris Hospital Tumor Conference*, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

#### **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

#### **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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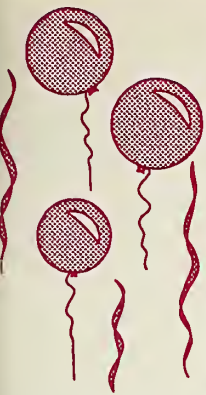
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# Happy 20th Anniversary, Arkansas AHEC Program!

This year, the Arkansas Area Health Education Centers (AHEC) Program celebrated its 20th anniversary. Founded in 1973 through the combined efforts of Governor Dale Bumpers, the State Legislature and the University of Arkansas for Medical Sciences (UAMS), the AHEC Program is the primary educational outreach effort of UAMS and the principal means of extending and decentralizing medical and other health professions education throughout the state.

Six AHECs in El Dorado, Fayetteville, Fort Smith, Jonesboro, Pine Bluff, and Texarkana serve as health care training sites for students in the fields of medicine, nursing, pharmacy and various allied health professions, as well as for medical residents specializing in family practice. The AHEC training approach emphasizes primary care, which covers general health care and health education for the whole family, including health promotion and disease prevention instruction and basic medical care.

## **The AHEC Mission:**

To improve the supply and distribution of health care professionals, with an emphasis on primary care through community/academic educational partnerships, to increase quality health care.

## **Specific Program Goals:**

- Enhance the quality of health professions education by using the best academic resources available statewide.
- Retain Arkansas graduates of health professions schools within the state.
- Improve the supply and distribution of primary health care providers in Arkansas.
- Provide health careers counseling and recruitment of students for health professions schools in Arkansas.
- Supply professional support and continuing education for health care providers statewide.
- Promote cooperation and coordination among communities, health care providers, educational institutions and health related organizations.
- Provide quality health care services and educational programs to the public.

## **AHEC Training Opportunities:**

- Recruitment programs that encourage high school and college students to consider careers in health care, with emphasis on rural and minority students.
- Rural clinical training opportunities for medical students in each year of their medical school training.
- Training for students in the UAMS Colleges of Nursing, Pharmacy and Health Related Professions, and other health professions schools throughout the state.
- Fully-accredited Family Practice Residency training programs in 5 AHECs, with the 6th program accepting its first residents in Fall 1993.
- Learning resource centers at all AHECs that offer a full range of health sciences library services and professional support for area health care providers.
- Ongoing continuing education programs for practicing health care personnel in all regions of the state.

## **Affiliated Community Hospitals 1992-93**

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**Northeast** - St. Bernards Regional Medical Center, Methodist Hospital of Jonesboro

**Pine Bluff** - Jefferson Regional Medical Center

**South Arkansas** - Medical Center of South Arkansas, Ouachita County Hospital

**Southwest** - St. Michael Hospital, Wadley Regional Med Center, Medical Arts Hospital

**Northwest** - Washington Regional Medical Center, Fayetteville City Hospital, Springdale Memorial Hospital, Rogers Memorial Hospital, Veterans Administration Medical Center, Baxter Regional Medical Center

## **20th Anniversary Celebration**

This year's 20th Anniversary milestone has been an important occasion for celebration. The Arkansas AHEC Program has become one of the largest and most respected programs in the country. Charles O. Cranford, DDS, Executive Director of the Arkansas AHEC Program, was elected Chairman of the National Organization of AHEC Program Directors to serve for the 1993-95 term.



# *The Beginning...*

## **Condensed Notes of Events Leading to and the Development of the Arkansas Area Health Education Centers**

Jeannette M. Shorey, M.D.  
George W. Warner

**A**s the Arkansas Health Education Centers Program celebrates its twenty years of existence, we will present some of the historical facts of how it came into being. The national events leading to its formation are taken from notes by George W. Warner who was the Assistant Dean for Financial Affairs in the School of Medicine from 1970 until his retirement in 1988. Mr. Warner was well acquainted with these events having been a member of the Special Grants Division of NIH and later was Director of Health Professions Student Assistance Grants Program, prior to coming to UAMS.

The information concerning the actual establishments of the various AHECs is taken from some of Dr. Winston K. Shorey's papers, now stored in the Archives at UAMS. Dr. Shorey was the Dean of the School of Medicine and became the first Director of the Arkansas AHEC Program.

The following material is a direct quotation from Mr. Warner's notes.

"The following programs evolved in the early 1970s following the phase out of the Federal Regional Medical Programs and a host of Federal Bureau of Health Manpower Programs: i.e., Health Professions Student Assistance Grants; Physician Augmentation Grants; Basic and Special Education Grants; all of which addressed decline in medical colleges' enrollment, maldistribution of physicians in practice, and the need for greater numbers and kinds of primary care physicians. Not to be overlooked in this sweeping amalgamation of programs and resources thereof, was an underlying premise that some eighty percent of physicians practice within eighty miles of the place where they completed their residency training.

"The late 1960 years were indeed challenging! Prior to the founding of the Arkansas Health Education Centers Program, Arkansas responded to these issues by increasing its first year enrollment five percent per year. A Department of Family Medicine was established. In response to the suggestion that medical colleges' curricula could be shortened from four to three years, Arkansas revamped its curriculum from the traditional nine month-four year progression to a nine month first year, seven month second year, a twelve month third year and an elective senior year. This was followed with an alternative senior year elective whereby students could opt for a Family Practice senior year which, it was proposed, would be accepted as the first year of their Family Practice Residency.

"These sweeping changes led by Dean Winston K. Shorey and Associate Dean Horace Marvin were then fortified by the Dean's insistence that a greater number of full time faculty were called for to meet these challenges and to extend and strengthen the College's Post Graduate Medical Education Programs.

"On receipt of the College's first offerings in 1971 and 1972 to participate in the Federal Area Health Education Centers Program, all stops were pulled. Deliberation of the College's Executive Council focused concerns regarding lack of resources to qualify and later for establishing self-sustaining support, faculty strength and the maturation of the Family Practice Program.

"Dean Shorey's response was "the Chairmen will come around to accept the challenge. We will do it. Our role is to serve as a Tertiary Care Center for Arkansas". At this time it was a singular effort on the part of our Dean. He became the most travelled physician in Arkansas. The theme on campus was "Faculty, foster



closer ties with physicians within the state. We need their support and they need ours!!"

"Specialty Divisions of the College became Departments; Dr. Lee Parker, a physician in practice in Fayetteville, accepted appointment as Director of Post Graduate Education, in December 1970. Dr. Kerrison Juniper, a Gastroenterologist and member of the full time faculty, volunteered to become Director of Educational Resources.

"Countless trips were made to possible AHEC sites: Fayetteville, Pine Bluff, Fort Smith, Jonesboro, El Dorado and Texarkana. Exchanges with the then leaders of the Arkansas Medical Society, physicians in private practice, hospital directors, the then Governor Dale Bumpers and members of the General Assembly were innumerable.

"The massiveness of developing a response to the Bureau of Health Manpower's offering came at a time when the campus lacked a print shop, the State's purchasing restrictions and time limited contractual services, electronic typewriters were in short supply, and administrative and clerical assistance doubled in kind to collate. Fortunately, the Regional Medical Program was still in its phase out, and Dr. Marion Silverblatt, Director, and his core staff provided great assistance.

"The solicitation called for matching resources with a demonstration that the State could ultimately fully maintain the support called for and a community commitment on the part of the sites selected as Area Health Education Centers.

"The Governor, members of the Arkansas General Assembly, the faculty, physicians in practice and the hospital leaders all responded enthusiastically.

"Now the fun began. What communities would be named and which would be phased in, and in what order? Would senior medical students fulfill off-campus electives? Would residents then in training be expected to rotate? Can we afford to have the faculty off-campus? What are the dividends? Do we need a Medical Air Service?

"Yes! Arkansas, after repeated, rejected responses to the Bureau of Health Manpower's offering, gained recognition some two years later via the Arkansas Legislature. Dr. Shorey resigned as Dean to become the first Director of the Arkansas Area Health Education Centers Program and capably led it to full fruition and recognition. It was and remains a success!!

"The Area Health Education Centers (AHEC) Program is an integral component of the colleges which compose the University of Arkansas for Medical Sciences Campus. The six AHECs initially proposed, i.e., Fayetteville, Jonesboro, Pine Bluff, El Dorado, Texarkana and Fort Smith are established. These programs focus principally on the State's primary health care needs. The gains and shortcomings of previous programs addressing physician shortages and maldistribution

have been met, advances in medical technology and communication continue."

To Mr. Warner's fairly complete historical background on the events leading to the establishment of the Arkansas Area Health Education Centers, I will add a few notes on the actual establishment of the first four centers to be opened. Elsewhere in this issue of *The Journal of the Arkansas Medical Society* can be found full accounts of the six centers.

The following information is taken from some of Dr. Winston K. Shorey's papers now stored in the Archives in the Library at UAMS.

In a paper written for the use of the then Governor Dale Bumpers, Dr. Shorey cites the very critical role played by the State Legislature in the establishment of the AHEC Program. He states that the appropriation of \$2,250,000 for the biennium 1973-74 and 1974-75 permitted the Administration of UAMS to implement their plans for the establishment of the first three of the State's Area Health Education Centers when Arkansas's application for a grant from the Health Manpower Bureau was denied.

With these funds available, the Administration at UAMS began in earnest to implement its plans to establish the State's Area Health Education Centers.

Dr. Shorey travelled throughout the State developing enthusiasm for the AHEC concept. He felt strongly that community support and cooperation between the local physicians and the Medical Center was imperative for the success of the venture.

In the spring of 1973 six cities were selected that met the criteria for an AHEC. Dr. Donald L. Miller was persuaded to give up his private practice and to become the Director of the AHEC to be established at Pine Bluff.

The Jefferson Regional Hospital and the people of Pine Bluff gave this new venture into health care their full support, and in the fall of 1973, the creation of the State's first AHEC got under way. Staff was appointed, office and clinic space were obtained, an adequate library was established under the direction of a trained librarian, and housing for prospective medical students and residents was obtained.

The Program was now off and running. With the appointment of Dr. James B. Weedman of El Dorado and the augmentation of Dr. Jacob Ellis, work began to open an AHEC in this community. The Warner Brown Hospital provided office space and room for a library. Arrangements were made to renovate a building that had housed the nursing school to be used as office and clinic space. Staff was appointed and the Center was ready for its first students June 1, 1974.

In December of 1973, Dr. J. Campbell Guilliland accepted the appointment of Director of the Fort Smith AHEC, and Mrs. Carolyn Moore, Chairman of the Division of Allied Health Programs at Westark College, was named Assistant Director. They set in motion the



steps necessary to open the AHEC at Fort Smith.

St. Edwards Hospital and Sparks Regional Medical Center gave their full cooperation to the new venture. Sparks Hospital Library was sufficiently adequate for student and resident use. The building which had housed the "Cooper Clinic" was obtained and renovated for use as office space and for an Outpatient Clinic.

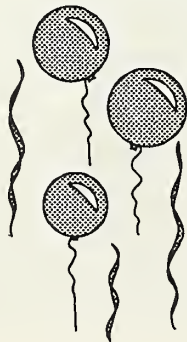
November '74 also saw the establishment of the AHEC in Fayetteville with the acceptance of Dr. Lee Parker as Director. He got the cooperation of the Washington Regional Medical Center, the Fayetteville VA Hospital, the Fayetteville City Hospital and the Springdale City Hospital to participate in the program and turned a building in downtown Fayetteville into an outpatient clinic so that Fayetteville was ready to accept family practice residents in July 1975.

As funds became available AHECs were established at the two remaining selected sites: in Jonesboro, under the Directorship of Dr. Robert B. Cohen in 1975, and in Texarkana under the leadership of Dr. James B. Kitrell in 1976.

It is a tribute to all those involved in the mammoth job of preparing for the teaching program for these first students that they were so enthusiastic about the training they received that they spread the word "This is where the action is". None of the AHECs has ever lacked for applicants since.

Following Dr. Shorey's death in January 1976, Dr. Roger Bost accepted the appointment as Director of the AHEC Program. Under his capable leadership it grew and expanded, and though each AHEC remains unique, they all have a very positive impact on their communities; have supplied good medical care to their patients; excellent training for their students and residents; and an important contribution to the education program at UAMS. The infant AHEC of 1973 has matured into a healthy, vigorous young adult contributing much to the medical community of this State.

As the Program celebrates its 20th year of existence under the leadership of its present director, Dr. Charles O. Cranford, it has maintained its reputation for excellence.



## Side Notes

The Area Health Education Centers (AHEC) program has been a major success in Arkansas. Originally initiated as an approach to supply family physicians to rural Arkansas, it has evolved into a six-center health education network that serves each region as a mini-medical center providing health education to all types of health professional students and serving as clinical practice centers providing direct health care to citizens, many of whom are unable to pay. As we celebrate the 20th anniversary of the AHEC program, this health education and service network is recognized as a core component of the University of Arkansas for Medical Sciences.

The success of the AHEC program reflects the contributions of many people and communities. Certainly, the individual AHEC directors and family medicine directors at each site deserve much credit but, of equal importance, has been the support of the local physician and hospital leadership. These programs were established as community-based centers and they thrived because of this commitment. It was probably fortunate that for the first decade of existence little, if any, federal support was available. This required state, UAMS and local support to establish a strong base. The more recent federal dollars have added excellence to the strong core funding but are not critical to the future existence of the program.

The future of the AHEC program is solid. It serves as the major training site for medical students in primary care and for housestaff in family medicine. It is a major site for nursing education and pharmacy and, recently, has been an active participant in allied health education. Arkansas still needs family physicians and other health professionals directed to rural practice. As we move to a managed competition model of medical practice, the role of the primary care practitioner becomes even more important and a national goal of 50% primary care can only be achieved by increasing the role of each AHEC site. In addition, the availability of telecommunication should allow us to develop a more rapidly responsive system for both education and service. Problems of isolation can be solved and retention of family physicians in rural communities enhanced. It is important that each AHEC site truly develop an "area" commitment and assist small hospitals with their unique needs. We have initiated this effort by developing sub-AHEC centers in most regions and working more closely with the physicians and community health centers.

In summary, the first 20 years of the Arkansas AHEC Program have been very successful. Strong leadership exists at each of the six sites and the future is in good hands. UAMS is committed to expanding these efforts to a greater level as the health care reform agenda develops goals of "access - quality - cost commitment" that are vital for the future of American health care.

**Harry P. Ward, M.D., Chancellor**  
**University of Arkansas for Medical Sciences**

*[EDITOR'S NOTE: At a recent area AHEC function Dr. Ward referred to AHEC's as "mini-medical schools". Since AHECs have programs for freshman, sophomore, junior and senior medical students and programs for nursing students, pharmacy students, and several allied health programs, one can legitimately use the term "mini medical school".]*





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# Continuing Education

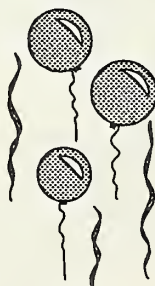
Lee B. Parker, M.D.  
Director, AHEC Northwest

UAMS has a long history of offering continuing education to health professionals of Arkansas. No effort has been made to study archives at UAMS but to this author's knowledge Dr. Willis Brown in OB-GYN and Associate Dean John Riggins were active in developing and offering continuing education programs for physicians in the late '50s and '60s.

Under auspices of a federal grant from the Regional Medical Program in 1970, UAMS embarked on a state-wide outreach program of continuing education for physicians, headed by this author with administrative assistance by Dean Shorey, Dr. Harry Ackerman in the audio-visual department and Dr. Kerrison Juniper of the Gastroenterology program.

Dr. Horace Murphy and Mr. George Warner offered much advice and encouragement.

Many faculty members of the College of Medicine participated regularly in going to selected sites, and any attempt to name them would invariably leave out some of the more faithful, so no listing of names will be attempted. As is so often the case the director got the lion's share of credit but the faculty actually did the work.



The program consisted primarily of arranging with local hospitals and their medical staffs to allow the introduction of two types of programs:

1. A faculty member would come once a month to the local community hospital where a lecture might be provided on a regular basis. He would also provide consultation on problem cases.
2. Audio visual programs were to be provided on a regular basis for use with A-V machines which were provided to each of the selected hospital sites.

The author's memory is not complete but some of the sites which participated were: Dermott, Dumas, Magnolia, Hope, Nashville, Mountain Home, Newport, Batesville and Helena. (An interesting anecdote was one case where the faculty member reported to the flying service in Little Rock about 6 a.m., gave his destination to the charter pilot and settled back to read his newspaper. Some 3/4 hour later instead of landing in Nashville, Arkansas he found himself east of Memphis heading for Nashville, Tennessee. Needless to say that visit was a complete bust).

Among the audio visual programs were films, combination slide-sound programs, filmstrips, and a self-teaching multiple choice type program in a machine which predated present day computer programs. (No VCRs were available then).

In addition, patient information programs such as Tel-Med were introduced; Medical Information Service by Telephone (MIST) which was a telephone consultation system, was studied and finally begun in the mid-late '70s; a telephone conference network was established with the University of Missouri which produced medical lectures on a recurring basis from the



University to some 8 to 10 sites across the Northern half of Arkansas.

With the establishment of the State AHEC program in Fort Smith, Pine Bluff, and El Dorado in 1973-74 and soon thereafter in Jonesboro, Fayetteville and Texarkana continuing education programs for physicians took a dramatic increase.

One of the major goals of the AHEC program was to provide good, accessible library services and to offer continuing education programs on a regular basis.

The author believes that the following figures from the AHEC Annual Report would support that these goals are being met exceptionally well: the combined AHEC libraries have approximately 10,290 books, 1,040 journal subscriptions, and 2,060 audio visual programs. More than 33,500 articles were copied and sent to users. In addition, approximately 1,374 programs for a total of 2,679 hours of continuing education were put on in 1991-92.

Lastly the last 5 to 7 years have seen an increase in continuing education for other health professions in each of the AHECs. These programs are for nurses, pharmacists, ER personnel, medical technology, radiographic technology, and biomedical instrumentation.

Thus we have seen an effort to make continuing education for health professionals readily available and accessible on a frequent and recurring basis in each area of the state and usually for a minimal or no fee to the attendees.

## Side Notes

At the twentieth anniversary of the founding of the Area Health Education Center program in Arkansas, it is clear that its programs have been a terrific success. AHEC contributed substantively to the development of the Department of Family and Community Medicine in Arkansas and serves to recruit UAMS medical students into family practice. It has influenced the dispersion of family practitioners into rural communities throughout the State. Almost all medical students take rotations supported by or at the AHECs. The AHEC has begun to address the needs for other health professionals in rural Arkansas. Of great importance has been the positive feeling that has been generated for UAMS through the AHEC's interactions with Arkansas citizens and the legislators. Its present programs, including the Delta initiatives and efforts to preserve rural hospitals, also address our state's needs.

Great emphasis will be placed on recruiting and educating students for the generalist specialties. This is desirable to meet the needs of society and essential for implementation of the basic components of health care reform. The AHEC will be a major contributor to future education of generalist physicians in Arkansas and to the development of a viable health care delivery system applicable to sparsely populated rural communities. It seems inevitable that the next twenty years will be every bit as challenging for the AHEC, and that AHEC programs are positioned to respond positively to the challenge.

I. Dodd Wilson, M.D., Dean, College of Medicine  
University of Arkansas for Medical Sciences

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# What is an AHEC "Worth" to a Community Hospital

Lee B. Parker, M.D.  
Director, AHEC-Northwest

**A**t one time or another each AHEC community hospital faces the issue of whether or not an AHEC program is worth anything to that hospital and its medical staff as well as the area served.

A definition of worth in the dictionary is: a thing that lends importance, value, or merit and is measurable by the esteem in which it is held.

In case of an AHEC which has multiple programs it is difficult to place things in a true perspective whether trying to do so from a purely monetary view or from some other view of value.

For example, in AHEC-NW there are programs involving freshman, sophomore, junior and senior medical students, a family practice residency of 18 doctors, nursing programs for students and post graduate programs for RN to BSN to MSN, pharmacy students, a medical technology program and a radiographic technology program.

In addition, there are multiple faculty for these programs plus a fully staffed medical clinic.

Overall, there are more than 50 persons working for this AHEC program with an overall budget that exceeds 2 million dollars - economically a nice industry for the area.

In trying to indicate value we will approach the issue by suggesting tangible values and in-tangible values.

## *Tangible values:*

### 1. HOSPITAL SERVICE UTILIZATION (1992-93 FIGURES)

	AHEC-NW	ALL AHECS
a. deliveries	252	1,757
b. hospital admissions	906	4,951
c. ER visits	968	8,083
d. nursing home visits	1,133	5,193
e. clinic visits	15,920	74,769
f. new patients	3,242	9,444

Out-patient referrals for lab,  
x-ray, physical therapy, etc.: unknown  
Referrals to other hospital staff members: unknown

2. In-house physician coverage
  - a. multiple residents are in-house parts of every day and in some cases all day.
  - b. on nights and weekends, one resident at all times with others on "back-up call".

These residents are available to assist nurses or other physicians in rendering care, answering questions, etc. In addition residents are available to assist in surgical, obstetrical and ER care and emergencies.

3. Direct Services by AHEC physician are provided for both in-patients and out-patients.

4. Many trainees settle in the area and use the hospital themselves or refer patients to other staff (22 from AHEC-NW in four county area around Fayetteville).

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*Happy Anniversary!*



5. AHECs finance and staff extensive medical libraries at each site with usage running into the thousands yearly. Each library site offers direct computer links with the Arkansas medical library network, several regional medical library networks and the MedLine, the National Medical Library. Service by the librarians is prompt and efficient.

6. AHECs offer clinical training opportunities for senior pharmacy students and library and faculty resources for area pharmacists pursuing post-graduate degrees (BS, Pharm to Pharm D).

7. AHECs offer several nursing educational programs in most locations. The most prominent of these is the RN to BSN to MSN program which allows area nurses to take and complete these degree programs locally by attending class and clinical sessions on a one day a week basis.

8. Most AHECs offer some form of Allied Health Professions educational programs. In Fayetteville, for example, we offer a medical technology program, BSMT, and a radiographic technology program. Other AHECs have similar programs and programs for respiratory therapy, paramedic, E.M.T., etc.

9. Several AHECs have established out-reach rural health clinics: Rison, Stephens and Lewisville are examples.

#### *Intangible benefits:*

1. Teaching opportunities are attractive and/or stimulating for some clinical staff physicians and the educational programs could not survive without the volunteer faculty who teach students on clinical rotations of all the mentioned programs.

2. AHECs offer hundreds of hours of continuing education yearly for many health professions. In AHEC-NW in 1992-93 this was 516.75 hours and statewide it was 2,304.5 hours.

3. The full range of medical education programs provides a very positive image for the associated hospitals. In AHEC-NW our programs are affiliated with Washington Regional Medical Center, City Hospital and V.A. Hospital in Fayetteville; Memorial Hospital in Springdale; and St. Mary's Hospital in Rogers. Each of those communities are also affected.

4. All AHEC community hospitals contribute financially in various ways toward each AHEC program, and without that administrative and financial commitment the AHEC programs could not easily survive.

On the other hand most of the financial burdens of each AHEC are met from generated professional services, state support through UAMS, and federal grants occasionally.

In addition, the administrative burdens of each AHEC are the responsibility of UAMS, the state AHEC program and the local AHEC programs, not the local hospital.

It has been widely assumed for many years that residency training programs are costly to their clinical hospitals because their students tend to order more tests and increase paper work.

This is not true in our experience in AHEC-NW. Our primary teaching hospitals, WRMC, has been in an ongoing evaluation of quality of care issues for over one year. The AHEC-NW faculty and resident practice compares better than average in length of stay and in quality of care than most other specialty groups, including family practice, in this hospital.

Finally, when one counts the tangibles and the intangibles, the positives and the negatives, the costs and the incomes, how does one compute the value of all of this to a hospital and an area.

None of these are a major part of the activities of the hospital nor the communities but it directly and indirectly touches every person and activity of the hospital, its staff and its patients.

It is a bit like trying to specifically list the reasons for our living and working in Fayetteville in my own case: there are the usual public services, the hills and lakes, the University of Arkansas, the climate, the people, etc.

None of these things alone is the reason for our choice but taken together, these things provide what most of us consider an enrichment worth living here to receive.

It is somewhat the same when one tries to measure the effect of an AHEC program in a hospital and in an area. The hospital and the area would still have its qualities but an AHEC offers an "enrichment factor" which cannot be measured in dollars and cents but is an enrichment never-the-less.





# The AHEC Libraries

Connie Wilson  
Librarian, AHEC Northwest

**I**n a scientific study, 95% of physicians said that information they obtained from the library contributed to higher quality care for their patients.<sup>1</sup> Physicians must have immediate access to current information to care for critically ill patients. Today the Area Health Education Center (AHEC) Libraries in Arkansas are doing their part in providing this information. As stated by the Executive Director of the AHEC Program, "a major priority of the Arkansas AHEC Program is improving the health professional's access to information."<sup>2</sup>

## THE SYSTEM WORKS!

ICU personnel at Warner Brown Hospital in El Dorado recently asked the AHEC librarian for assistance. A major chemical accident had seriously injured a worker with hydrogen sulfide burns to his face. The librarian immediately performed a computer search on MEDLINE, a bibliographic database produced by the National Library of Medicine which indexes over 4,000 biomedical journals from around the world. The librarian produced a bibliography of several articles of which the library had two. Within twenty minutes, the library staff photocopied these and delivered them to the ICU. Within a few minutes of the first call, the attending physician called the library for information on the company doctor being flown in from Mexico. A third call, from the consulting ophthalmologist, requested articles on the management of hydrogen sulfide injuries to the eye. The articles retrieved were available from the Library of the University of Arkansas for Medical Sciences (UAMS). The UAMS library staff transmitted the needed materials via telefacsimile (Fax) to the El Dorado AHEC Library. In less than two hours, the physicians

attending this critically injured patient had the needed information to make the informed decisions regarding management. Conveniently, the information on the company doctor arrived before he did. The ophthalmologist was delighted - not only did the articles answer his needs, but one of the articles was written by an old school classmate!

This real life scenario occurs daily in emergency rooms and intensive care units in hospitals throughout Arkansas. The AHEC Libraries are available to assist health professionals to obtain the most current information so that health professionals can provide the best patient care. The state established a library with each AHEC site. Each AHEC Library is located in or near the largest community hospital where the AHEC centers are established. Each library is staffed with at least one full time librarian who provides literature searches, photocopying services, interlibrary loan services, and maintains book, journal, and audiovisual collections. A new information center, the Delta Health Education Center Library (DHEC) was established in 1990. The DHEC librarian, located in a community college library in Helena, directs a federally funded program to provide current medical information to health professionals along the Delta region.

By far the most significant decision to affect the AHEC Libraries was the adoption of the Arkansas Plan for State-Wide Medical Library Service, developed by the director of the UAMS Library, Ms. Rose Hogar (1966-1990). Each AHEC Library offers library services to all health professionals within its service area, regardless of their affiliation with the AHEC program. The (UAMS) Library serves as resource to health professionals in central Arkansas and secondary resource to



the AHEC Libraries in Arkansas. As advances in medical technology continue to occur at an ever faster rate, it becomes critical that health professionals have access to the information concerning these. Few states have such a wide ranging plan to provide all health professionals an entry into the Biomedical Communications Network established by the National Library of Medicine. The network allows a physician from Small Town Arkansas to gain access to the information housed at the National Library of Medicine, if the needed material is not available within his/her state or region.<sup>3</sup> The Libraries function as an entry point for all health professionals to the Biomedical Communication Network.



**NATIONAL LIBRARY OF MEDICINE**  
**RESOURCE LIBRARIES**  
**AHEC LIBRARIES**

## NUMBER CRUNCHING

In 1991-92, more than 31,000 health professionals utilized the AHEC Libraries within the state. The six AHEC Libraries responded to more than 21,000 requests for information, and performed more than 6,300 computerized searches of the literature. The collection of the entire AHEC Library system include approximately 10,290 books, 1,040 journal subscriptions, and 2,060 audiovisual titles. Finally, almost 32,000 articles were copied and 1,500 articles sent via telefacsimile during 1991-92.

The AHEC Libraries can help provide a myriad of health information on all aspects of health related problems with which people in the field are grappling. The AHEC Libraries provide literature information to

hospital administrators to support purchase of new technology. Physicians make use of literature searches to assist in choosing treatment modalities. Nurses seek the latest information on procedures to support making policy changes.

## TECHNOLOGY IMPACTS ON LIBRARIES

Several of the AHEC Libraries have acquired the Compact-Disk Read Only Memory (CD-ROM) based systems for searching the health related databases. The AHEC libraries use online interlibrary loan computer systems through OCLC, DOCLINE and "fax" technology to bring the world's medical literature to health professionals in rural Arkansas.

Computer technology for searching and requesting the medical literature has opened the world's medical literature to rural physicians throughout Arkansas. The National Library of Medicine is encouraging individual health professionals direct access to the literature via their GRATEFUL MED software which accesses their databases, including MEDLINE. The LOANSOME DOC module linked to GRATEFUL MED allows the individual health professional to electronically order articles from the search performed on GRATEFUL

MED. The AHEC Libraries receive Loansome Doc requests from individual health professionals daily. The impact of telefacsimile has allowed the medical library to become an important participant in patient care decision making by getting needed information to the bedside quickly.

## NEW DIRECTIONS

Today, the AHEC and DHEC Libraries are expanding their roles by traveling outside their libraries to demonstrate and teach the different ways health professionals can gain access to health information. The Access Library Consultant, funded in 1993 and located in the Jonesboro library, is evidence to this effort. In addition, AHEC/UAMS librarians are exhibiting at statewide meetings such as the Arkansas Medical Society annual meeting to increase awareness among health professionals of medical information resources. These efforts will continue as the technologic advances continue to make information access easier for the individual health professionals throughout Arkansas.



# Research at the Area Health Education Centers

Raymond C. Bredfelt, M.D.  
Residency Director, AHEC-Northwest

Although the six Area Health Education Centers (AHECs) in Arkansas are best known for the training of health care personnel and the delivery of patient care, research has also been an important aspect of these programs. During AHEC's twenty years of existence several dozen research projects have been developed, many of which have resulted in publication or presentation at national meetings.<sup>1</sup>

During AHEC's early years, most of its research activity centered on determining Arkansas' physician manpower supply and needs. Although it may seem obvious now, this data clearly established that Arkansas was in need of a significant number of family physicians and other primary care providers. Once the AHECs became firmly established the opportunity existed for further research activities - many of a more clinical nature. Over the past ten years these studies have included such diverse clinical topics as the use of the cervical cap for birth control, nursing home nutrition and sudden infant death syndrome. A number of clinical drug trials have also been undertaken, particularly at the Fort Smith AHEC. These studies have ranged from the treatment of hypertension and community-acquired pneumonia to the use of low dose aspirin in the prevention of pre-eclampsia and the treatment of hilar membrane disease with surfactant. Survey type studies have also been conducted on such diverse topics as family physicians' opinions regarding the care of AIDS patients to the impact of obstetrics in family medicine on medical student decisions regarding specialty and residency selection.

In October, 1990, the Arkansas AHEC Program began a major project called the Demonstration of Dissemination of Medical Technology within the Health

Education Centers. Its purpose was to assess the effectiveness of different strategies of relaying new clinical information to physicians (CME, computer conferencing, video and audiotapes, etc.). The AHECs at Pine Bluff, El Dorado and Texarkana participated in the two year project with Fort Smith serving as control.

In all these ways, the AHECs have been actively involved in research activity. While no cure for cancer or the common cold has been forthcoming from these activities, many important pieces of information have been obtained and utilized.

Perhaps the greatest misconception that exists concerning research is that it must be performed in "Ivory Towers". The AHEC Family Practice Centers are certainly a long way from "Ivory Tower" status-yet research is ongoing in these sites. Tremendous opportunities also exist for physicians in practice to investigate the everyday perplexities of medical practice. Often times incredible discoveries are brought to light through the interaction of patients with their physicians. In 1777, Dr. Edward Jenner was informed by a patient that the cowpox she had recently contracted was fortunate since it protected against smallpox! This little piece of folk wisdom resulted in the eventual eradication of smallpox from the face of the earth.<sup>2</sup> Approximately 180 years later, Curtis Homer, a country doctor in Claxton, Georgia, became interested in the high rate of cardiovascular disease in his region. His interest led to the association of several risk factors with this disorder.<sup>2</sup>

Hardly a day passes in medical practice in which patients ask questions with no documented answer; or a standard therapy is given with little verification of effectiveness. All these instances are potentially investigatable. Should any physician in practice in our state develop an interest which he/she would like to



# Discover The Elegance Of A Hybrid



At first glance, it's the *beauty* of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its *elegance* becomes apparent—a gentle blend of softness and strength.

At first glance, it's the *enhanced performance* of Vaseretic that catches the eye. But study Vaseretic more closely, and its *elegance* becomes apparent. The way its one-tablet, once-a-day dosage minimizes multiple

medications. Minimizes insurance copayments. And minimizes potassium supplementation.

A hybrid *blending of tolerability and power* that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

And an elegant discovery for your practice.

**USE IN PREGNANCY:** When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Vaseretic® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

**VASERETIC® 10-25**  
Enalapril Maleate-Hydrochlorothiazide

*Next*

Dosage must be individualized, the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.



**USE IN PREGNANCY:** When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC (Enalapril Malate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

**CONTRAINDICATIONS:** VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

**WARNINGS:** General: Enalapril Malate; Hypotension: Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, Drug Interactions, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

**Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided. (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

**Neutropenia/Agranulocytosis:** Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, Drug Interactions; Enalapril Malate and Hydrochlorothiazide).

**Pregnancy, Enalapril-Hydrochlorothiazide:** There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 1/2 times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 1/2 times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See Enalapril Malate, Fetal/Neonatal Morbidity and Mortality, below.)

**Enalapril Malate, Fetal/Neonatal Morbidity and Mortality:** ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no

alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contradiction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be associated by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

**Hydrochlorothiazide; Teratogenic Effects:** Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4-5.6 mg/kg/day (approximately 1-2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

**Nonteratogenic Effects:** These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**PRECAUTIONS:** General: Enalapril Malate; Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

**Evaluation of the hypertensive patient should always include assessment of renal function.**

**Hemodialysis Patients:** Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69®) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

**Hyperkalemia:** Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See Drug Interactions.)

**Cough:** Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pain or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see Drug Interactions, Agents Increasing Serum Potassium).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the

treatment of metabolic alkalosis. Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

**Information for Patients; Angioedema:** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**Pregnancy:** Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

**NOTE:** As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

**Drug Interactions: Enalapril Malate; Hypotension—Patients on Diuretic Therapy:** Patients on diuretics and especially those in whom diuretic therapy was recently initiated, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

**Agents Causing Renin Release:** The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

**Lithium:** Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium. Hydrochlorothiazide: When administered concurrently the following drugs may interact with thiazide diuretics:

**Alcohol, barbiturates, or narcotics—**potentiation of orthostatic hypotension may occur.

**Antidiabetic drugs (oral agents and insulin)—**dosage adjustment of the antidiabetic drug may be required.

**Other antihypertensive drugs—**additive effect or potentiation.

**Cholestyramine and colestipol resins—**Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively.

**Corticosteroids, ACTH—**intensified electrolyte depletion, particularly hypokalemia.

**Pressor amines (e.g., norepinephrine)—**possible decreased response to pressor amines but not sufficient to preclude their use.

**Skeletal muscle relaxants, nondipolarizing (e.g., tubocurarine)—**possible increased responsiveness to the muscle relaxant.

**Lithium—**should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

**Non-steroidal Anti-inflammatory Drugs—**In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

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# Side Notes

**[EDITOR'S NOTE: This article is comprised of excerpts from a speech by Dr. James Dennis, Chancellor of UAMS 1970-1979. A blue-ribbon committee appointed by then Governor Bumpers to study the medical needs of the State and make recommendations had filed its report, and there were both educational and political pressures to respond promptly and positively to the needs and recommendations.]**

**By merely changing a few names and dates, one could almost give this speech again in 1993 and it would be appropriate. The public uproar and dissatisfaction with the health care system is again reaching crisis levels in 1993. The Clinton administration in Washington D.C. is expected to release its recommendations about health care very soon (likely before this is published). Medical educators and professionals will again face critical decisions to change or fight, adapt or face extinction.]**

**[In referring to a change in government financial support and relationships] "...it's a new ballgame...and you better know the rules and understand the game...fight it and lose...failure to adapt...means extinction.**

**"We find that we have huge deficits in availability of health care in our rural areas as well as some of our inner city areas.**

**"Figures indicate that too many of our medical school graduates have gone into non-primary care specialties...90% of the health care needs in Arkansas are in the areas of primary health care.**

**"The proposal developed so beautifully by your Dean, Dr. Shorey, for Area Health Education Centers, which I have preferred to call mini-medical schools...health professions education. It addresses a number of issues: the big problem of distribution of health personnel and the lack of post-graduate training slots (half the class has to leave the State for internships and residency programs).**

**"There will be regional health education centers (A.H.E.C.s) in the cities of Jonesboro, Fort Smith, Pine Bluff, El Dorado, Fayetteville and Texarkana where there are large community hospitals and their staffs are very competent.**

**"Establishment of opportunities for all of our graduates to train in this State must be a goal.**

**"Let it happen; let us adapt to change; let us enjoy change; let us build upon change; we have some opportunities now that are not present for a lot of medical schools. Don't fight responses to social need; find a way to meet them."**

## ADDENDUM COMMENTS BY DR. DENNIS IN 1992

That talk was the accumulation of two years of frustration of trying to accomplish things through conferences and diplomacy. I was not a character, at least I feel I wasn't, and at the same time listening to this brought back a focus in time/space relationships and all that was going on - it was unbelievable. Dr. Mullins recruited me by asking me to do some of the things that I felt needed to be done and he gave me a charge of "turning the medical center around", getting it in tune with the needs of the State and desires of the leaders of the State and of the University and there was much pressure everywhere.

The impact of the things I brought up there made me feel good as I reflect on them because as a result of the

bone marrow assay.

**Enalapril Maleate:** There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times\* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times\* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagenicity test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vitro* cytogenetic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

**Hydrochlorothiazide:** Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

**Pregnancy:** Pregnancy Categories C (first trimester) and D (second and third trimesters). See WARNINGS, Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.

**Nursing Mothers:** Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: **Body As A Whole:** Syncope, chest pain, abdominal pain; **Cardiovascular:** Orthostatic hypotension, palpitation, tachycardia; **Digestive:** Vomiting, dyspepsia, constipation, flatulence, dry mouth; **Nervous/Psychiatric:** Insomnia, nervousness, paresthesia, somnolence, vertigo; **Skin:** Pruritus, rash; **Other:** Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

**Angioedema:** Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

**Hypotension:** In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

**Cough:** See PRECAUTIONS, Cough.

**Clinical Laboratory Test Findings, Serum Electrolytes:** See PRECAUTIONS.

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

**Serum Uric Acid, Glucose, Magnesium, and Calcium:** See PRECAUTIONS.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

**Liver Function Tests:** Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

**Enalapril Maleate:** Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: **Body As A Whole:** Anaphylactoid reactions (see PRECAUTIONS, Hemodialysis Patients); **Cardiovascular:** Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; **Digestive:** Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; **Hematologic:** Rare cases of neutropenia, thrombocytopenia and bone marrow depression. Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported; a causal relationship to enalapril has not been established. **Nervous System/Psychiatric:** Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); **Urogenital:** Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; **Respiratory:** Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; **Skin:** Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pemphigus, alopecia, flushing, photosensitivity; **Special Senses:** Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing.

**Miscellaneous:** A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia/myositis, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.


**Fetal/Neonatal Morbidity and Mortality:** See WARNINGS, Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.

**Hydrochlorothiazide—Body as a Whole:** Weakness; **Digestive:** Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; **Hematologic:** Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia, **Hypersensitivity:** Purpura, photosensitivity, urticaria, necrotizing angitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; **Musculoskeletal:** Muscle spasm; **Nervous System/Psychiatric:** Restlessness; **Renal:** Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); **Skin:** Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; **Special Senses:** Transient blurred vision, xanthopsia.

\* Based on patient weight of 50 kg.

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further investigate, the resources of their local AHEC or of the Department of Family and Community Medicine at UAMS stand ready to advise, assist or co-investigate. If a cure for the common cold is ever forthcoming, it seems equally likely to come from an observation reported to or by a physician caring for patients than from a researcher in an "Ivory Tower".

## REFERENCES

1. Area Health Education Center- Annual Reports 1980-1992.
2. American Academy of Family Physicians: Practice-Based Research in Family Medicine. AAFP. Kansas City, 1985.

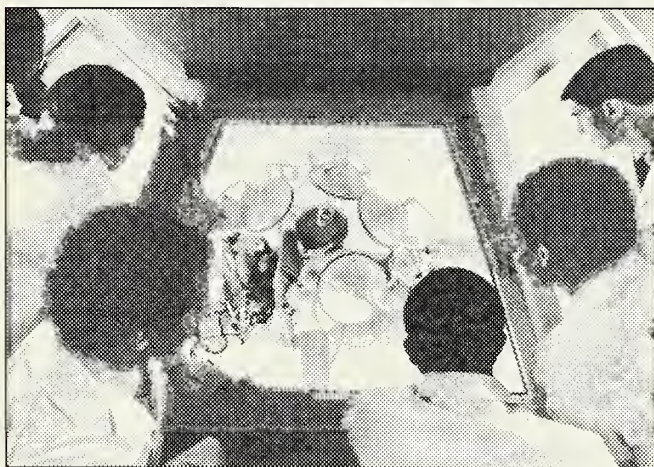
## Side Notes

(DENNIS cont.) proposed relationships and getting everyone involved in planning and communicating came the faculty assembly for the entire campus with representation from students on up. From the standpoint of heading towards goals, it did lead to a better opportunity to go the direction that we felt was necessary.

Certainly the AHEC programs, which were not funded by the federal people until 1986, were advanced and Dr. Shorey and I were always real good friends. We had intellectual and honest differences in terms of goals and I don't recall any real issues except I wanted to have more of an outreach program. I also wanted to have a local AHEC in Little Rock with the medical school as its core and as a centerpiece for family practice in the University and this got nowhere.

**James Dennis, M.D., Chancellor, 1970-1979**  
**University of Arkansas for Medical Sciences**

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# Arkansas AHEC Family Practice Residency Programs

## *A Progress Report*

Donald L. Miller, M.D.  
Director, AHEC-Pine Bluff

Since the inception of the University of Arkansas for Medical Sciences Area Health Education Center programs in 1973, a major thrust has been to provide more primary health care physicians for the state.

Objectives toward this goal have been addressed by the establishment of family practice residency training programs in all of the six Arkansas Area Health Education Centers.

AHEC-based family practice residencies benefit immensely from local hospital and community support. Without the enthusiastic teaching efforts of local physicians, who serve as clinical faculty members, these community based programs could not exist. The situation provides the residents with excellent clinical training in a cost-effective manner, while expanding the primary care base of the AHEC cities and areas.

In the early years of AHEC family practice programs, there was a tendency for the trainees to leave the residency after the first year - mostly to answer the lure and enticement associated with private general practice. This trend reversed after the first few years so that now it is quite unusual for a resident to fail to complete the program. Those that do so leave for training in a specialty other than family practice.

In the 1960s to early 1970s, medical school graduates from UAMS College of Medicine numbered about 100 per year. More than 50% of these graduates had to leave the state for further post-graduate training because of the paucity of internship or first year residency (PGY-1) positions available in Arkansas. An estimated 80% of these Arkansas trained physicians never returned to practice in Arkansas.

Currently, the UAMS College of Medicine and AHECs offer 153 PGY-1 positions. The graduating class

for the past several years has averaged 130 students. It is evident that a significant number of medical school graduates of out of state schools are being recruited to fill the residency positions available in Arkansas.

By providing additional postgraduate positions, the AHEC family practice residency programs have been a significant factor in retaining more Arkansas graduates in the state. At present, the AHEC residencies offer 32 first year family practice residency positions. The UAMS based family practice residency in Little Rock offers eight first year positions, for a total of 40 PGY-1 in-state family practice training slots. The increased interest of Arkansas graduates in family practice and other primary health care specialties is becoming more evident. Thirty-five 1993 graduating seniors, from a class of 135, chose family practice careers. Twenty-two of these were matched to AHEC residencies.

The first family practice residency programs were initiated at AHEC-Northwest (Fayetteville) and AHEC-Ft. Smith in 1975. Residents were first accepted at AHEC-Pine Bluff in 1977, and at AHEC-Northeast (Jonesboro) and AHEC-South Arkansas (El Dorado) in 1981. The AHEC-Southwest (Texarkana) implemented the sixth AHEC family practice program with four residents entering July 1, 1993.

Through June 1993, a total of 262 family practice physicians have completed the three year AHEC programs. Of these, 195 (74.5%) are in practice in Arkansas.

Among those located in Arkansas, 140 are practicing in cities and towns of 30,000 or less population, with 73 in towns less than 10,000, 25 in cities of 10,000 to 20,000, and 42 in cities of 20,000 to 30,000 people (Table I).

Among the 262 AHEC family practice graduates 177 (67.5%) were recruited from the UAMS College of



Medicine senior classes. Eighty-five (32%) were from out-of-state medical schools and 43 (51%) of these have remained in Arkansas to practice. A total of sixteen graduates are from osteopathic colleges of medicine (Table II).

To date, 225 of 238 (95%)\* have been successful in becoming board certified by the American Board of Family Practice, and are actively involved in ongoing continuing medical education.

Considering the current shortages of family practice physicians, plus increased demands and requirements anticipated by changes in health care policies and programs, the importance of the Arkansas AHEC family practice residency programs will become increasingly recognized.

\*Does not include 1993 graduates of AHEC residencies.

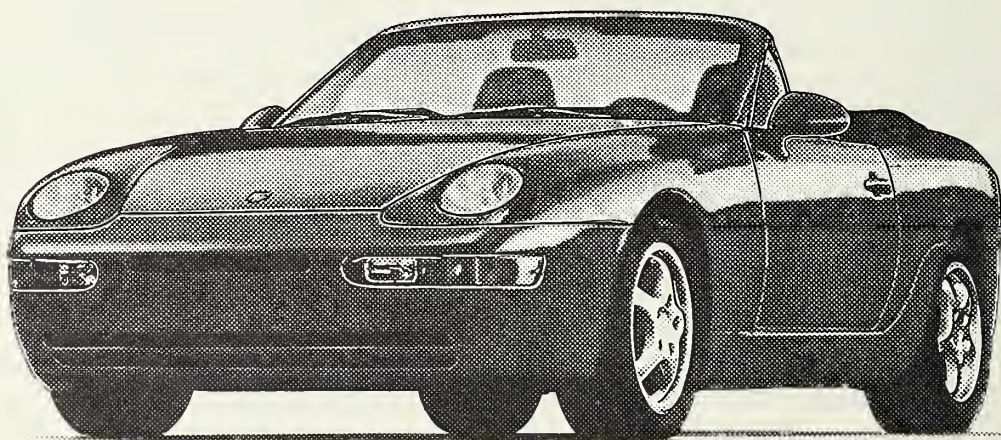
**TABLE I PRACTICE LOCATIONS - AHEC FAMILY PRACTICE PROGRAM GRADUATES, 1975-1993**

PROGRAM & YEAR INITIATED	NUMBER COMPLETING PROGRAM	PRACTICING IN ARKANSAS	TOWNS LESS THAN 10,000	CITIES 10,000 TO 30,000
AHEC-FT. SMITH 1975	65	51	15	20
AHEC-NW (Fayetteville) 1975	58	38	14	14
AHEC-PINE BLUFF 1977	66	48	20	11
AHEC-SOUTH ARKANSAS (El Dorado) 1981	35	25	10	16
AHEC-NE (Jonesboro) 1981	38	33	15	6
TOTALS	262	195	73	67

**TABLE II UNDERGRADUATE MEDICAL EDUCATION - PHYSICIANS COMPLETING AHEC FAMILY PRACTICE PROGRAMS, 1975-1993**

PROGRAM	UAMS COLLEGE OF MEDICINE GRADUATES	OUT OF STATE MEDICAL SCHOOL GRADUATES	OSTEOPATHIC COLLEGE GRADUATES
AHEC-FT. SMITH	42	23	1
AHEC-NW (Fayetteville)	33	25	3
AHEC-PINE BLUFF	44	22	9
AHEC-SOUTH ARKANSAS (El Dorado)	23	12	2
AHEC-NE (Jonesboro)	35	3	1
TOTALS	177	85	16

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# Addressing Arkansas' Rural Primary Care Challenges

Geoffrey Goldsmith, M.D., M.P.H.

Garnett Professor and Chairman

Department of Family and Community Medicine, UAMS

*[Editor's note: This article was written in February, 1993 prior to the rush toward "health care reform" and "managed care", which have dominated medical news recently. Some "hub and spoke" networks are becoming a reality in Warren, McGehee, Helena, McCrory and Salem. The Arkansas Department of Health has received a planning grant to compete for a program grant to develop new innovations in education and delivery of health care in rural areas of Arkansas.]*

## ABSTRACT

Universal health coverage may become a reality by the year 2000 and implies a greater need for primary care physicians in rural Arkansas in the 21st century. We can start this decade to build the capacity for an outstanding rural primary care system for the next century. The number of rural primary care physicians can be increased by 1) placing a high priority on recruiting more students to primary care, 2) improving the attractiveness of rural practice, and 3) improving the long-term financial viability of rural primary care. The quality of rural primary care will be greatly influenced by changes in information technology. Medical outreach activities from urban centers to rural communities and changes in rural medical infrastructures will be necessary as we approach the year 2000.

## START TODAY PREPARING FOR THE NEXT DECADE

The federal government appears committed to universal health coverage. This commitment will give all Arkansans access to primary health care and will mean even more demand on our state's primary care physicians at a time when primary care providers are in short supply in Arkansas' rural counties.<sup>1</sup> There must be substantial increases in the number of primary care

providers if we are to avoid a crisis in the delivery of primary care within the rural areas of Arkansas. In order to recruit and retain rural physicians, the attractiveness of rural practice will have to increase. This article will focus on how we can help strengthen rural primary care in Arkansas.

## AVAILABILITY OF PRIMARY CARE PHYSICIANS

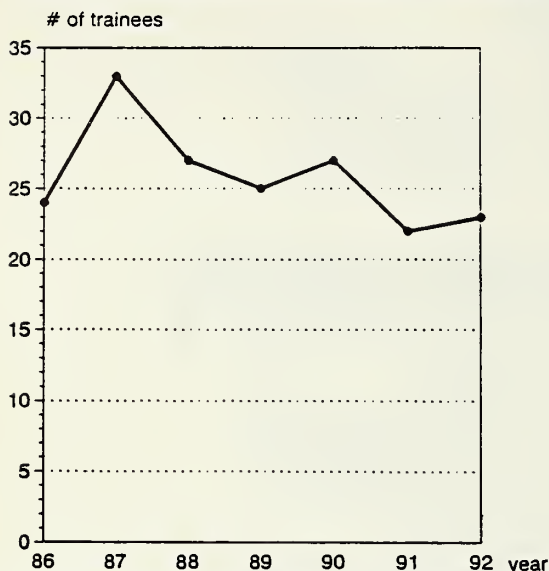
There is general agreement that the number of medical students who enter primary care careers must increase QUICKLY to meet projected needs for the year 2000.<sup>2,3,4</sup> Most health experts agree that if federal health insurance coverage expands primary care's affordability, the nation's current shortage of primary care physicians will worsen.

Making the attainment of an adequate number of family physicians even more difficult is the fact that interest in family practice nationally and within the state began to level off in the mid 1980s (Figure 1). Four years after graduation, approximately 35% of UAMS College of Medicine graduates enter primary care. This track record compares very favorably to other U.S. medical schools (within the top 15% of all U.S. medical schools), but for the next century in Arkansas, we'll need to have a least 50% of the graduates enter primary care until we've made up for the existing shortage of several hundred primary care clinicians. Based on success stories at several medical schools, the journey to 50% of trainees in primary care is a substantial but not impossible goal to attain.

What can the medical schools do to meet the state's rural primary care needs? Changing medical school admissions to place a priority on recruiting students interested in primary care - especially those students interested in rural careers - adding required pre-clinical

Figure 1

Number of UAMS Graduates Choosing Family Practice Residency



and clinical training with clinicians in rural and AHEC areas, increasing training in community settings, and reducing financial burdens of primary care students are some of the most promising approaches.

Expansion of the number of Arkansas' family practice residency training slots by 50% will allow for more Arkansas based training. Since about 75% of our family practice residents remain in the state to practice, the expansion of training opportunities will help solve the primary care shortages during the 21st century.

The state should add more funds to develop the infrastructure of rural medicine, facilitate rural hospital conversion and reconstruction, and improve rural patient transportation systems.

The federal government has been progressively increasing its role in rural health care. There are many existing rural health programs (Table 1) that can be expected to grow.<sup>5</sup> The federal role in Arkansas' rural primary care system in the next decade will go beyond anything that we have experienced to date. To provide better care for rural populations, the federal government will be investing heavily in community health centers and supporting rural certified clinics, and there will be an increase in the number of National Health Care Service primary care positions by about 8,000 nationwide. The federal government is already providing medical schools incentives to place trainees in primary care underserved communities and has instituted a dramatic change in the medical student loan program so that interest in a primary care career is an essential selection criterion.

#### MAKING RURAL PRIMARY CARE MORE ATTRACTIVE

AHEC, the UAMS Medical Center, the UAMS College of Medicine, Arkansas' State Offices of Rural Health

and Primary Care, and regional hospital outreach programs will need to enhance the rural practice environment through continuing education, on site training and consultation in the rural community, and technical support of the rural practice. A number of these activities have been started recently. The formation of rural "hub and spoke" primary care networks was proposed recently by the Arkansas Office of Rural Health.<sup>6</sup> This approach offers the potential for outreach to small communities, improved backup through networking, locum coverage, involvement in teaching and research, and CME and technical support from hospitals and UAMS.

#### ACQUISITION, DISSEMINATION AND INCORPORATION OF MEDICAL KNOWLEDGE INTO PRIMARY CARE

The decade of the 1990s has been characterized by experts in information technology as the beginning of the "plugged in" era. This term implies the wide availability of low cost computer assisted information channels. The capability of linking any location with another via satellite or fiber-optic cable transmission is technologically possible in this decade, and UAMS will soon have a system that links some of the AHEC sites to the UAMS campus.

Medical information technology (MEDICAL INFORMATICS) in the 21st century will allow the widespread, quick and low cost dissemination of medical data, be it audio or visual. This technology can be incorporated in rural practices over this decade. Lead-

TABLE I

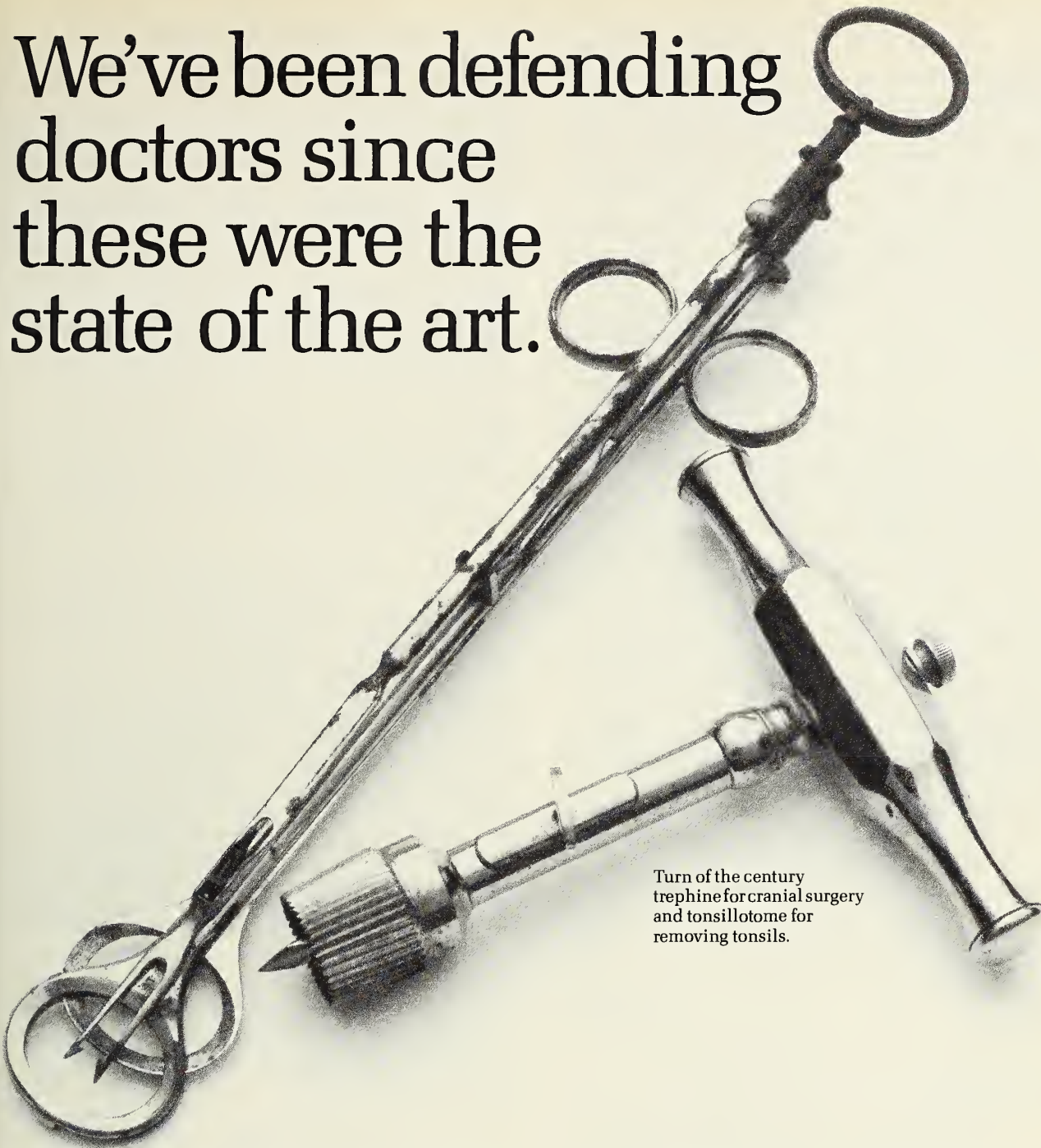
#### CURRENT FEDERAL EFFORTS TO STRENGTHEN HEALTH CARE IN RURAL AMERICA<sup>1</sup>

- \* Rural Health Clinics
- \* Block Grants for Maternal, Child, Preventive Care and Mental Health
- \* National Health Service Corps
- \* AHECs
- \* Primary Care Student Loan Program (as of 1993)
- \* Community Health Centers
- \* Primary Care Training Grants
- \* Rural Health Care Policy Research
- \* Medicare Rural differentiated pay in health manpower shortage areas
- \* Rural Referral Centers Program
- \* Sole Community Hospital Program, Rural Primary Care Hospital, and Essential Access Community Hospital Program

1. Office of Technology Assessment, "Health Care in Rural America," 1990.



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ership and guidance by UAMS and AHEC will quicken the transition of medical informatics to rural health care settings. During this decade, standards for sharing medical data in Arkansas will have to be agreed upon; a low cost communications network linking all Arkansas' medical providers awaits design, funding and implementation.

Medical Informatics must flourish in rural primary care since it is in primary care that one must integrate a massive and growing medical knowledge database to solve the widest variety of patient health complaints. Also, consultants are less available to rural practices, and medical informatics can help bridge the information spectrum from primary to tertiary. In the 21st century, AHEC and the College of Medicine, using advanced medical informatics and telecommunications, might be able to quickly disseminate the latest medical research breakthroughs, develop quality assurance protocols and decision support programs to every rural primary care physician's office.

Computer aided instruction affords a low cost opportunity for continuing medical education. Continuing medical education programs throughout the state should be involved in the creation of a common language, in-office, computer assisted CME program available for all primary care physicians.

Specialist UAMS faculty now visit some rural sites to provide consultation. This popular program will hopefully be commonplace in the later 1990s. Eventually, consultants may be available to the office based rural primary care physician in "real time" via a state-wide telecommunications system.

Looking at another approach to rural primary care CME, UAMS and AHEC centers might offer flexible "mini-fellowships" to rural primary care physicians who would visit the training centers a day a month, several weeks per year, or at other convenient time intervals.

**CREATION OF "SYSTEMS" MEDICINE IN ARKANSAS**

The primary care physician functions optimally when he/she is part of a well articulated health care delivery system. Such a system extends beyond the elements of primary care to include secondary, tertiary and quaternary health care. Health care providers in Arkansas will move toward an integrated health care system that includes the rural primary care physician. By the 21st century, there is likely to be multiple managed care networks within the state established to provide vertically integrated clinical care for large groups of patients. Working closely with community based physicians and hospitals, AHEC could play an important role in assembling a vertical health system that incorporates rural primary care providers and primary care health services research and teaching into managed care systems.

**RURAL HEALTH INFRASTRUCTURE**

There has been far too little investment in the infrastructure that will be needed to support rural primary care. Investment in brick and mortar facilities (and the conversion and updating of existing facilities) and changes in organizational structure will have to occur on a major scale. A federal study panel explored a number of options that might be used to improve the entire rural health care system (Table 2) and some of these ideas may be tried in Arkansas.<sup>5</sup> The rate of change in rural health systems will quicken and become driven by the reality that without change, the current rural health system will lose patients to urban centers and jeopardize rural populaces' health status.

**CHANGES IN THE REIMBURSEMENT SYSTEM AND FINANCIAL VIABILITY**

Among all developed nations, the differences in the United States in compensation for primary care compared to specialist care is the most disparate. Whether the above changes will narrow the difference in compensation by a significant degree is only speculation, but narrowing of the difference would encourage some students to enter primary care.

The viability of rural primary care will in part rest on the financial attractiveness of rural primary care, compared to urban settings. The economic incentive to practice primary care in rural Arkansas is inadequate compared with that of specialist practice in cities. The solution of this major societal problem will depend on the efforts of state and federal government and the medical marketplace. At this point, none of these groups have indicated an intention to increase substantially the revenue of rural health care providers.

TABLE II

LONG-TERM STRATEGIES TO IMPROVE RURAL HEALTH CARE IN AMERICA <sup>1</sup>	
*	Convert rural hospitals in a fashion to better meet community needs.
	Create urban-rural medical and hospital partnerships.
	Restructure the corporate organizations of hospitals.
	Form hospital cooperatives.
	Establish primary care facility satellites or multi-centers.
	Establish primary care networks in rural communities.
	Merge health facilities and providers.
1.	Office of Technology Assessment, "Health Care in Rural America," 1990.



One way to improve the financial viability of rural primary care is to shift more diagnostic procedures to the rural primary care physician's office. AHEC and the College of Medicine would be well advised to embark on an aggressive program to train rural primary care physicians to competence in the widest range of office based procedures. Not only would such an approach help stabilize rural providers and hospitals revenues, but it would also improve convenience for the patient and lower health care costs.

The health care financial environment will become increasingly complex. Effective management of a small business, which is in essence the task that faces the primary care physician and clinic manager in private practice, is a learned skill. While primary care physicians are already recognized as lower cost providers of diagnostic health care, even more intensive training in practice management will become necessary to provide financial survival skills for rural physicians and their staffs.

#### **THE FUTURE SUCCESS OF RURAL PRIMARY CARE WILL STAND ON THE "SHOULDERS" OF PAST SUCCESSES**

The development of a strong AHEC system two decades ago that was designed to train family physicians and other providers of rural health was based on the assumption of a shortage of these clinicians in rural Arkansas. The forecast of a shortage of family physicians was accurate, and the gravity of the problem was profound. While improvements in rural health manpower have been substantial, geographical pockets of primary care health manpower shortage in all Arkansas counties still remain. The Arkansas Office of Rural Health recently estimated that the number of family physicians entering into practice in Arkansas over this decade will only be enough to replace those physicians retiring and/or leaving practice. The number of new family physicians being currently trained in Arkansas will not substantially decrease the existing shortage of primary care physicians.<sup>5</sup> The shortage of primary care physicians will only worsen if universal coverage of primary care services becomes available.

About 20 years ago, UAMS recognized that a severe shortage of family physicians existed in Arkansas and began to increase family practice education on campus and develop a decentralized, AHEC based medical education. A successful AHEC and Department of Family and Community Medicine cooperative effort was created. The vision and forces that created and supported this magnitude of expanded primary care training must again be brought to bear to prepare the Arkansas rural health care system for the 21st century.

## *Side Notes*

It is a particular pleasure for me to comment on the collaboration between the Area Health Education Centers Program and the College of Health Related Professions (CHRP). Sharing AHEC facilities and with their strong faculty and administrative support, this college has been able to expand a number of its programs into underserved areas of Arkansas. Most notably among these are our recently begun programs in radiologic technology in Northwest Arkansas (Fayetteville/Springdale/Rogers) and in Texarkana, our respiratory care programs in Texarkana and Pine Bluff, and the clinical rotation portion of our medical technology program in Northwest Arkansas, Pine Bluff and Texarkana. By offering these programs exclusively or substantially at those sites, students who might not have the opportunity to come to Little Rock for their professional education have been able to enroll. These programs benefit both the graduates and the AHEC cities and surrounding areas in that the graduates are much more likely to remain and practice in those areas, where there is an acute shortage in many cases of these important healthcare professionals.

The AHEC Program has also been working with us in providing library support for these students as well as assisting us in the development of distance learning programs, which have already begun to allow us to teach specialized classes from UAMS in Little Rock to the students in the AHEC locations. Working with the AHEC program, the CHRP has thus been better able to meet its statewide mission for providing allied health educational programs to Arkansans who need them.

**Ronald H. Winters, Ph.D.**  
**Dean, College of Health Related Professions**

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# Area Health Education Centers & College of Health Related Professions

## *A Partnership to Solve Health Care Shortages*

Herbert B. Wren, M.D.  
Director, AHEC - Southwest

For many years the Colleges of Medicine and Nursing have been associated with the Arkansas AHECs through student rotations at individual sites. More recently, the College of Health Related Professions has joined forces with AHECs Southwest, Pine Bluff, and Northwest to alleviate health professional shortages specific to these areas. This relationship is different from the other UAMS colleges because off campus schools have been developed allowing area students to receive degrees without having to leave their hometown.

At AHEC-Southwest, local hospitals were concerned about shortages in Respiratory Care, Radiologic Technology, Physical Therapy, and Medical Technology. Apparently, area students were completing prerequisite course work at Texarkana College and moving to either Little Rock or Conway to complete professional requirements and rarely returning because of job offers in Central Arkansas upon graduation. Area hospitals were spending recruiting dollars to attract local students back to Texarkana with hopes that these students would stay longer due to family ties. St. Michael Hospital and Wadley Regional Medical Center approached AHEC-Southwest for assistance in establishing local programs.

With this arrangement, students could continue to work on prerequisites at Texarkana College, complete the professional program in Texarkana and receive their degree from the University of Arkansas for Medical Sciences or the University of Central Arkansas without commuting. In the Spring of 1990, faculty was hired through AHEC-Southwest for Radiologic Technology and Respiratory Care. Funding for Radiologic Technology and Physical Therapy Assistant programs

came from St. Michael Hospital while Respiratory Care was funded through a federal grant applied for by AHEC Southwest.

The role for AHEC-Southwest personnel was to assist with faculty and student recruitment, facility planning, and working with Texarkana College to ensure that all prerequisite courses were appropriate for allied health students. The first class of Respiratory Care Associate degree students enrolled the summer of 1990; five students graduated in May of 1991, four in May of 1992 and twelve are currently enrolled. Twelve students will be accepted for the fall of 1993. There are two full time faculty for the Respiratory Care program.

The initial class for Radiologic Technology began in the fall of 1990 with this class graduating four students in May 1992. Five students will graduate in May 1993, six are currently enrolled, and nine will be accepted for the fall of 1993. This is an associate degree program, but students also have the option of pursuing their bachelors degree from UAMS by taking additional courses at East Texas State University. With this program, there are also two full time faculty members.

The Physical Therapy Assistant program was initially set up differently by offering courses at night and on a part time basis. It was felt that students interested in this particular program were currently working in a clinic and could not afford to quit their daytime job to attend school. Twelve students graduated from the first class and thirteen are currently enrolled. Faculty members are both local physical therapists and instructors from UCA.

Medical Technology is the latest school to be established in Texarkana. This program is different in that students can work on two years of prerequisites at

Texarkana College, attend UAMS in Little Rock during their junior year, and complete their senior clinical year at St. Michael Hospital earning their bachelor of science degree. The first student will graduate in May 1993 and four have been accepted for the fall of 1993. One full time faculty person is coordinating this program.

AHEC Northwest has also established similar programs in the areas of Medical Technology and Radiologic Technology. Seven students are currently enrolled in Radiologic Technology with four of these students graduating in May 1993; seven new students are expected to enroll in the fall of 1993. The Medical Technology program will graduate its first class with four students in May 1993 and another five will start during the fall of 1993 for their senior year.

AHEC-Pine Bluff has the longest history of all the Arkansas AHECs of providing allied health programs. An associate degree program in Radiologic Technology was established in 1979 with the University of Central Arkansas. This two year program has graduated nearly 100 students with an average class size of sixteen.

Another school which offers a certificate for aspiring Respiratory Technicians is cosponsored by UAMS and AHEC - Pine Bluff has had fifty five students enrolled since its inception in 1989. This one year program has graduated twenty seven students allowing this group to complete their associate degrees in Little Rock in just seven months.

Students completing their bachelor of science degree in Medical Technology from UAMS can complete their senior year at Jefferson Regional Medical Center. This nine month program has had seven graduates with four students currently enrolled.

Certification programs in specialty areas of Emergency Medical Technician (EMT) and Paramedic are also offered at AHEC-Pine Bluff. The EMT course is three to four weeks in length and was offered for the first time in 1988. Over 180 students have completed this much needed program. In 1989, a one year Paramedic course began with forty six students having enrolled while 26 of these have graduated from the program. These programs have assisted area health facilities with shortages in critical areas while providing students educational programs without commuting to a larger city.

Many of the graduates have remained in the AHEC area supporting the initial theory of where students complete their professional course work will likely be close to their first job after graduation. Students seem to appreciate these local health care career options being available without the inconvenience of commuting to complete course work.

The future for allied health programs appears secure. More tasks in the medical fields will be performed by those whose preparation has allowed them to focus on a narrower range of specific needs. There will be a

team approach to providing specific diagnostic and treatment functions. Physicians and nurses caring for patients in a variety of settings from outpatient sites to Intensive Care Units will want and need the help of allied health professionals.

As greater demand arises for health care in the future, allied health professionals will be called upon to supply this care. This should also be a more cost effective solution to the problem of rising prices. Training in the allied health field can be done successfully at the local level using the concept of cooperative education combining efforts from universities, local community colleges, hospitals, the medical community and coordinative support from the AHECs.

As one graduate of an AHEC based respiratory care program recently stated, "The respiratory care program offered by AHEC-SW and UAMS has given me the opportunity to have a rewarding career without having to leave my hometown. I was hired part-time while still a student and acquired a full-time position one week after graduation. After a year and a half of clinical experience, I was promoted to Supervisor of Pulmonary Services. I would never have gotten this far in any career without the AHEC Program."

—Karen Diles, RTT, RCP  
Supervisor of Pulmonary Services  
Texarkana, Arkansas

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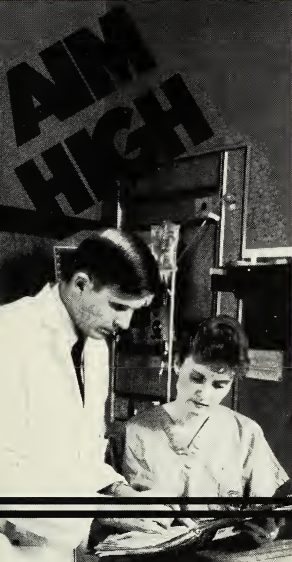
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# Arkansas AHEC Program

## *Past and Future*

Charles O. Cranford, D.D.S., M.P.A.  
Executive Director, Arkansas AHEC Program

**T**wenty years rush by. Medical students graduate. Residents complete their training - not just in Little Rock, but in communities throughout the state. An Arkansas program grows into a model for the nation.

Supported by UAMS, Governor Dale Bumpers, key legislators, health care practitioners and civic leaders, the Arkansas AHEC Program began its pioneering work in 1973. Departing from the big-city hospital model, educational centers were established in each of six regions of Arkansas with the goal of improving the supply and distribution of primary health care personnel and the quality and scope of their education.

Arkansas's physicians have grown along with the AHEC Program: for some it was a chance to teach, for others it was the opportunity to complete a medical residency program near or in the community to be chosen later as a new home and practice site. For medical students, it has been the opportunity to do clinical rotations in Jonesboro, Texarkana, El Dorado, Pine Bluff, Fort Smith or Fayetteville.

AHEC faculty and staff are derived largely from the communities in which the six centers are located. A fundamental reason for the success of the community-based AHEC model is the assimilation of persons from the area being served. The program is based on UAMS' close partnership with health professionals all over Arkansas, a novel association that allows UAMS resources to be invested in regionally-based programs.

Arkansas physicians are eager to teach. That desire is enhanced when the teaching efforts promise future health or health care benefits to their own communities,

e.g., a future resident physician at the local hospital, a medical student's decision to pursue primary care, or a commitment by a health care trainee to return to the community to practice.

*[EDITORS NOTE: Most clinical faculty are unpaid volunteers.]*

### AHEC GOALS

AHEC Program goals, set 20 years ago, were designed to meet the needs of students and practicing health professionals in communities throughout our state. These goals continue to produce dramatic results in recruitment of needed healthcare professionals in rural Arkansas communities.

A significant factor in AHEC's success is that the first and foremost mission of UAMS is to meet the complex health needs of Arkansas. A highly effective means of accomplishing this ambitious goal has been to place the last phase of formal education for family practice residency programs in regional centers scattered throughout the state. This approach is based on the premise that the best way to increase both the supply and the caliber of family practice physicians is to increase the number and quality of residency positions in strategic locations statewide. While other states downsized residency programs in the 1980s and 1990s, Arkansas increased the number of family practice residency positions.

### ARKANSAS AHEC TODAY

The Arkansas AHEC program is a primary care educational program that is a fundamental element of



the education of physicians-in-training at UAMS. As the principal means of regionalizing medical education in Arkansas, quality training experiences were provided to more than 300 medical students this year alone! Medical students are given options for AHEC experiences during each year of their training. These options include rural preceptorships, clerkships and senior electives.

A statewide organization of six family practice residency programs, affiliated teaching hospitals, libraries, volunteer faculty, preceptors, ambulatory care centers, private medical practices, area advisory councils, non-profit foundations, affiliated special purpose health care institutions, community health centers, health departments, and others make up AHEC's statewide network. Using multidisciplinary teams of full- and part-time faculty, who are complemented by more than 550 clinical faculty, the AHEC model grants students the privilege of working side-by-side with practicing health professionals in hospitals, clinics, and private practice environments statewide.

- **The Rural Preceptorship Program** introduces pre-clinical medical students to practice in smaller Arkansas communities. Last year the program had a total of 118 students, with 93 physicians in 55 rural communities.

- **The four-week Family Practice Clerkship** is provided to junior students, focusing on outpatient management of medical problems commonly encountered by family physicians. Last year, 111 of 136 junior medical students completed clerkships at AHECs and in Little Rock.

- **The Senior Elective Rotation** program trained 73 senior medical students via 166 rotations in private practices at AHEC-sponsored locations throughout the state.

- **AHEC Family Practice Residencies** have been completed in Arkansas by more than 262 family practice physicians since 1973 - of these, 75% have elected to set up practice in Arkansas! Since 1989, 45% of these residents have settled in small towns with less than 10,000 persons.

- **Continuing Education** programs for virtually every medical discipline are sponsored regionally by the AHECs so that health care practitioners can be kept current on new technologies via workshops and conferences.

The AHEC Program also serves as a major provider of Medicaid services and health care for the medically indigent. The AHEC Program is the most accessible provider for many Arkansans who are unable to pay for services.

A network of six AHEC-based libraries are linked with the UAMS central library and major libraries nationwide, including Medline, Cancer Lit and Internet. Information and materials can be accessed quickly and

at a low cost by physicians throughout the state. Plans are underway to develop this network so that it is more user-friendly and accessible to more physicians.

## AHEC LOCATIONS

The strategic locations of the six AHEC-based family practice residency programs have served to enhance their selection by UAMS students and graduates, as well as to influence their ultimate choices for permanent practice locations. Moreover, as more family practice physicians have been trained in the AHEC residencies, an ever-increasing percentage have chosen smaller communities in which to set up practice.

Since 1987, five of the six AHECs have moved into larger, improved facilities that allowed for more health care services and an increased number of student and resident trainees. In Arkansas, the AHEC Program is based on a hub and spoke concept. The hub communities are the six cities in which AHEC facilities are located. Last year, 84 smaller communities served as "spokes".

## AHEC FUTURE

Several other new programs are on the horizon, including an exciting compressed video telecommunications network to connect UAMS with each AHEC. This linkage will permit more efficient and effective delivery of continuing medical education by UAMS faculty and will even make way for emerging technologies that will allow some medical services to be delivered or supported by two-way video technology!

Expanded educational experiences for medical students and residents to learn from physicians in smaller communities and expanded involvement with community health centers to deliver services to low-income patients are also being planned. AHEC Programs will enhance physician recruitment to these centers and will significantly expand the scope of services delivered. AHEC facilities themselves will undergo continuing improvement in order to maintain an outstanding educational support network for Arkansas physicians.

Arkansas physicians are to be congratulated for 20 years of AHEC Program accomplishments. The AHEC Program has relied heavily on their contributions and support of program goals. Arkansas physicians have been the local liaisons that have enabled AHEC to connect with their local communities.

As health care reform is being debated, many questions remain unanswered. However, this is certain: *more primary care physicians will be needed in Arkansas*, particularly in our smaller towns. The Arkansas AHEC Program offers the most effective means of producing those primary care physicians.

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# The Development of Clinical Pharmacy Practice in the Arkansas AHEC Program

Tom Frank, Pharm. D.  
AHEC-Jonesboro

**T**he earliest record outlining the potential activities of a clinical pharmacist in the Arkansas AHEC program was detailed in a memo in 1982 written by Dr. Lee Parker. Many of the ideas stated in that proposal are now a part of everyday life at AHEC. As anyone in academics knows, three more ingredients are required after ideas are put forward: funding, commitment and personnel. The 1% increase in sales tax which occurred in 1983 played a substantial role in the financial initiative. A long term goal of UAMS involved diversification of the health professions training in the AHEC programs throughout the state.

So what would a clinical pharmacist in the AHEC program do? To answer this question, one must look at clinical pharmacy practice and develop a sense of what contributions to health care are provided by that type of professional. In simplest terms, a clinical pharmacist is a drug therapy expert with additional clinical training that focuses on the evaluation and implementation of drug therapy options and alternatives. Many clinical pharmacists have selected specialized practices in areas such as pharmacokinetics, nutrition, oncology, psychiatry, long term care, infectious disease, ambulatory care and other areas of specific practice. These individuals train in accredited post-graduate residency programs covering specialty areas in a structured format of practice or fellowships designed to facilitate research interests. What was needed in the AHEC program was a generalist in a vein parallel to the family medicine physician. The successful practitioner would know a little about a lot rather than a lot about a little.

As originally conceived, the clinical pharmacist at AHEC would serve as a consultant and educator of the family medicine residents training at AHEC. This

person would also provide a clinical practice rotation experience for pharmacy students during their senior year.

I filled the first AHEC clinical pharmacist position in 1985. It rapidly became apparent that the possibilities of substantial diversity and favorable impact were present. Several critical factors were necessary to stimulate this process. The strong consistent support of the AHEC director and the hospital pharmacy director where I practiced was critical. Plenty of time spent listening to the needs regarding drug therapy education was also an important part of determining the most appropriate course to take. The audience rapidly expanded to include community physicians in private practice and community pharmacists.

It is important to remember where we were in drug development during the mid-1980s. An era of impressive pharmacologic achievement that began in 1977 with the introduction of cimetidine was at a maximum of productivity, profitability and imitation. New aggressive marketing strategies resulted in a premium being placed on objective presentation of data to sort through the confusion. Additionally, new information was frequently being published regarding drug intervention in numerous conditions of great interest to primary care providers. The need to assess and impart this information into the practitioner's treatment strategy provided an unending array of opportunities.

Clinical pharmacists have been placed in almost all of the AHEC centers. This has been possible through cooperative efforts with the UAMS College of Pharmacy and in some cases by sharing positions with the local hospital. Currently, the clinical pharmacists in AHEC are: AHEC-Fort Smith - Charles Marsh, Pharm.D., AHEC-Northwest - Lois Coulter, Pharm.D., AHEC-

Pine Bluff - Joseph Udeaja, Pharm.D., and AHEC-Southwest - Lottie Harrell, Pharm.D. Individuals who have left AHEC positions over the years include Barbara Mason, Pharm.D., Jim Lindsay, Pharm.D., and Rockridge Hannah, Pharm.D.

It is difficult to write in a global fashion about pharmacy practice in the AHEC system because each practice in the AHEC system is different just like each AHEC is different. The goals, personalities, needs and facility all interact to form unique environments that have gross similarities. In one AHEC, clinical research receives more intense emphasis while in another the emphasis is shifted toward a heavier teaching load or a more active clinical practice. Interestingly, these focal developments tend to evolve based on circumstance instead of fulfilling some pre-ordained mission.

What is a typical day like for a clinical pharmacist at AHEC? It usually involves some time in the morning making rounds in the hospital reviewing new information on the patients our residents have in the hospital. Usually this is done as a part of teaching rounds but is sometimes independent. The focuses of this activity are primarily teaching and quality assurance. Some time will be spent in the clinic during the day as well. In some cases, this will involve chart review or patient education but most often it involves consultation from the residents related to specific patient management problems they have. Each day residents and faculty members meet to review and discuss patients in the hospital. This is a forum often used to address specific points of drug therapy management for the entire group. I use the early afternoon for small group teaching sessions or providing consultations that have been requested by private physicians for patients in the hospital. Pharmacy students, medical students, first and third year residents who are participating in drug therapy rotations are a part of these activities. Late afternoon is used for returning phone calls, a bit of reading or preparing for the next day. Sprinkled elsewhere into the schedule are trips to the nursing home, preparation for pharmacy and therapeutic committee activities in the hospital or work on written or verbal presentations to be provided to AHEC faculty and residents at regular sessions.

A recent case provides an example of a typical clinical intervention. We recently had an elderly debilitated nursing home patient in the hospital with pneumonia. The patient's condition worsened shortly after admission and she spent several days in intensive care on the respirator. She received broad spectrum antibiotics with appropriate care and was able to be transferred to a regular room after four days. She was improving except for a significant complaint of painful swallowing. After evaluation, she was diagnosed as having esophageal candidiasis and started on ketoconazole. Her problems with swallowing did not improve over the weekend. During rounds Monday, I

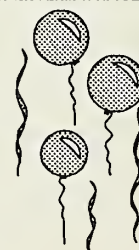
was made aware of the problem and noticed that the patient was still receiving a histamine-2 blocker for stress ulcer prophylaxis. Ketoconazole needs an acidic environment to be absorbed. The histamine-2 blocker was stopped and the patient's swallowing complaints resolved within two days.

The major function of the AHEC clinical pharmacist throughout this process is information provision. The most commonly sought areas of information are antibiotics, adverse drug reactions, hormone supplementation, interactions, interpretation of drug levels, hypertension and economic considerations of drug therapy. With the proliferation of new products mentioned earlier, there is an additional challenge and opportunity. Each of these products comes complete with a pharmaceutical sales representative extolling the virtues of the new products. Clinical pharmacists in the AHEC program work diligently to see that accurate and appropriate information is provided within AHEC.

Desire for access to a drug therapy expert is not limited to local health care providers. Numerous continuing education experiences have been provided over the years by AHEC clinical pharmacists in small communities and metropolitan areas. Inherent in the AHEC philosophy is the desire to enhance the practice of the primary care provider, especially in rural setting. Many patient education presentations and support group sessions have been led by AHEC clinical pharmacists. In my experience, these are often enriching experiences for the speaker in ways that are quite unexpected. Almost all of us got into health care to help people. In this forum, that desire is converted to action.

Clinical pharmacy practice has made a substantial impact upon health care in the AHEC system. The future has numerous opportunities and challenges - residency programs for pharmacists, increased clinical research opportunities such as research networks, enhanced patient communication programs, and the continued rapid development and evaluation of new therapeutic options.

In a social setting, one is often asked, "What do you do?", as an inquiry regarding their type of work. Almost anyone understands if you say you are a banker or florist, but they rarely have a clear idea if you say you are a clinical pharmacist. I finally arrived at an answer that hopefully speaks for all the AHEC clinical pharmacists when I answer, "I promote rational drug therapy."





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# Nurse Education in the Arkansas AHEC Program

Beth C. Vaughan-Wrobel, Ed.D., R.N., F.A.A.N.  
Associate Dean for Academic Programs, College of Nursing  
Assistant AHEC Director of Nursing Education, UAMS

**T**he focus of the Arkansas Area Health Education Center (AHEC) program, when implemented in 1973, was to provide educational opportunities for primary care providers and to increase the number of doctors practicing in rural areas of the state. Although nursing students had the opportunity to complete an independent study rotation at the AHECs, it was not until 1986 that nursing education, as an integral component of the AHEC program, emerged. As a result of a request to the State Board of Higher Education for special funds (appropriated under Act 33 of the 1983 First Extraordinary Session), monies were received to improve and expand health profession educational opportunities in the AHECs. Nursing was one of several disciplines targeted for this program initiative.

With the monies obtained from this award, two full time doctorally prepared nurse educators were hired. In December 1985, the first Director of Nursing Education began at AHEC-Northwest in Fayetteville and followed by the second nursing faculty, who joined AHEC-South Arkansas in El Dorado in the fall of 1986. Since that time, the nursing education program in the AHECs has continued to grow until currently there are nursing faculty located at AHEC-Northwest in Fayetteville and the subAHEC in Mountain Home, AHEC-South Arkansas in El Dorado, AHEC-Southwest in Texarkana, and AHEC-Northeast in Jonesboro.

As the number of nurse educators in the AHECs increased, the need for a centralized organization emerged; thus, the Arkansas AHEC Nursing Education Council was created in 1987. This group meets to share ideas and communicate with each other about what is happening in nursing education in their AHEC region.

The goal of AHEC nursing education is to provide

learning experiences which help to produce excellent nurses, while helping to achieve a better distribution of nurses through Arkansas, particularly in rural and medically underserved areas. This goal is accomplished through four major activities: community based graduate and undergraduate education, continuing nursing education, consultation services, and special projects.

## Community Based Graduate and Undergraduate Nursing Education

Through outreach efforts of the College of Nursing at the University of Arkansas for Medical Sciences (UAMS), nursing students are able to complete a portion of their studies at AHEC-Northwest in Fayetteville, AHEC-South Arkansas in El Dorado, or AHEC-Southwest in Texarkana. Both the BSN completion and the articulated BSN/MNSc programs allow registered nurses to complete the baccalaureate degree through courses offered on a part time basis at the AHECs in Fayetteville and El Dorado. Twenty-one nurses will graduate with their baccalaureate degree in May 1993, as the first graduates of these outreach efforts.

Ten hours of graduate nursing course work have been offered in Texarkana for the past two years, decreasing the amount of commuting required by students who live in this AHEC region. In addition, due to the articulated BSN/MNSc outreach program, nurses in the Fayetteville and El Dorado AHEC regions have been able to take graduate courses closer to home.

A telecommunications system, resulting from another grant received from the Department of Higher Education, is being installed connecting UAMS and the University of Central Arkansas with AHECs in Fayetteville, El Dorado and Fort Smith. Starting in the fall 1993, undergraduate and graduate courses will be



offered to students in these three areas using the telecommunications system. Ultimately, this system can be used for continuing nursing education as well as academic offerings.

Baccalaureate students in the UAMS nursing program have the option of completing an ambulatory care elective at an AHEC. Students who spend time in the AHECs have always been very positive about the learning experience in these primary care settings. Students from other nursing programs may arrange through the nurse educator for learning experiences in the AHECs. Several programs have requested specific experiences for their students through the AHECs.

## Continuing Nursing Education

Continuing nursing education programs are conducted in each AHEC region for all levels of nursing personnel. Formal needs assessments, site visits, and planning committees are used to plan, implement and evaluate each AHEC's continuing nursing education activities.

In 1990, the AHEC Nursing Education Council conducted a statewide continuing education needs survey. The results of this survey have provided guidelines for continuing education offerings in each AHEC. Continuing education activities have been offered for nurses in many different fields of practice: critical care, oncology, geriatrics, psychiatric, maternal/infant, emergency, management, education and medical/surgical among them.

## Consultation Services

Each AHEC nurse educator is available for consultation and technical assistance to institutions with nursing personnel. Services include assisting employers with educational planning and staff development activities. One nurse educator is a lawyer and has assisted agencies in her region with legal issues pertinent to nursing practice. Other areas of consultation have included the nursing process, personnel management and documentation.

The nurse educator is always available for career counseling and is often called upon to talk to groups about career opportunities in nursing and health care. All nurse educators participate regularly in career days at local colleges, high schools and hospitals.

## Special Projects

Special projects are determined by needs arising at each AHEC and many include patient and community education programs, medical and nursing research, and community service projects. For example, the nurse educator in El Dorado implemented a parenting project that received funding from several agencies and continues to meet a need in that community.

The Arkansas AHEC nursing education program,

## Side Notes

The College of Nursing has always considered its major mission to be education to meet stateside needs. In 1986, the first nurse faculty member was appointed to a nurse educator position in AHEC-Northwest to implement this mission directly in the community. Since that time, seven additional nurse educator appointments have been made in five AHECs. All of these nurse educators have held College of Nursing faculty appointments. The AHEC system and the support for nursing education has made it possible for the College of Nursing to provide nurses in stateside communities continuing education programs and formal course work leading to the baccalaureate and master's degree.

Over the past seven years, numerous continuing education programs have brought up to date information to nurses in remote rural communities. Entire series of programs such as a collaborative program to prepare critical care nurses have been developed and implemented to meet community needs in nursing. In 1991, with the support of the AHEC and the nurse faculty, a baccalaureate completion program which allowed completion of the degree and for select students, ten hours of graduate credit, was implemented in AHEC-Northwest in Fayetteville and AHEC-South Arkansas in El Dorado. These programs, delivered in their entirety in the community, helped to address the need to further the education of nurses in their home setting on a part-time basis. Studies have shown that nurses who complete advanced degrees in their rural communities tend to remain there for employment. This May, we will have 17 graduated from this unique program.

The AHEC system has also allowed the college to extend graduate course offerings to the rural areas of the state in Texarkana, Jonesboro, Fayetteville and El Dorado. Graduate students have been able to complete a number of required courses in these areas. This has reduced commuting time and has made the goal of obtaining the master's degree more feasible.

In keeping with the College of Nursing's missions of research and service, the AHEC system has also served the college as a direct avenue into the various state communities. Faculty conducting research have been able to receive assistance with accessing data sources and making community contacts essential to their studies. Service related projects have also been made easy through the assistance and support of the AHEC.

The AHEC has offered a unique partnership in meeting the missions in the college. It has allowed us entry in to communities, support for programming needs and a willing and creative partner in new and innovative projects. Together we have been able to bring the best of academe to citizens throughout the state.

**Linda Hodges, M.D., Dean, College of Nursing  
University of Arkansas for Medical Sciences**

over the past seven years, has certainly contributed to the accomplishment of the goals of the statewide AHEC program. Through its efforts, hundreds of nurses in rural Arkansas communities have benefitted from the many educational opportunities provided.



# Outdoor MD

Information provided by  
the Arkansas Game & Fish Commission

## BIRDERS ENJOY LAND, WATER TOURS AT LAKE CHICOT STATE PARK

Guided tours by land and by water are available for bird enthusiasts to view migrating shorebirds and songbirds at Lake Chicot State Park, just outside Lake Village.

Park naturalist Don Simons said the tours give visitors a look at wood storks, egrets, herons, purple martins and a variety of other birds. The area is normally good for birding during late summer as songbirds and smaller shorebirds migrate along the Mississippi Flyway to the Gulf of Mexico and farther south for the winter. Larger shorebirds move north after nesting along the Gulf, he said.

On the land tours, Simons leads groups in car pools to various sites in Chicot county to see birds, often driving on top of the big levees along the Mississippi River. Martins are often present in large numbers, and Lake Village has been designated "Purple Martin Capital of Arkansas." The auto tours must be arranged in advance by phoning 265-5480, but there is no fee.

On water tours, Simons escorts visitors by barge through a cypress swamp where hundreds of egrets gather in treetops in the evening. Other birds and wildlife like beavers, raccoons and mink can be seen, along with an occasional alligator.

The hour-and-a-half barge tours cost \$3.76 for adults, \$1.88 for children 12 and younger. Advance reservations by telephone are recommended because seating is limited.

## ARKANSAS JOINS NEW TOLL-FREE FISHING HOTLINE PROGRAM

Arkansas has joined four other states in a new national fishing hotline program, which features recorded information on a variety of fishing topics.

By dialing 1-800-ASK-FISH, an outdoors enthusiast is directed to the appropriate phone buttons after instructions.

Along with Arkansas, the program is now operating for Oregon, Florida, Kansas and Mississippi. Other states are expected to join the program in the next several months.

The toll-free hotline is a project of the national Sportfishing Promotion Council to increase sportfishing awareness and activity by giving anglers instant information over the phone.

These topics are covered in the recorded messages:

1. Current fishing report, statewide fishing information updated weekly by the Arkansas Game and Fish Commission and by its counterparts in the other states.
2. Information on where to buy fishing licenses, with locations selected by the caller's zip code.
3. Finding places to fish by entering a city name or telephone prefix then selecting the type of water desired.
4. Current regulations that apply to a specified body of water and a specified type of fish.
5. Places to launch boats in specified areas.
6. Finding campgrounds handy to fishing areas.
7. Fishing areas accessible to wheelchair users.

## LAWSUIT SETTLEMENT CREATES FUNDS FOR HABITAT, EDUCATIONAL WORK

Major improvements to waterfowl habitat on Bois d'Arc Wildlife Management area near Hope are being funded from a settlement in an environmental lawsuit.

The Arkansas Game and Fish Foundation has received \$400,000 from Hudson Foods, Inc., headquartered in Rogers, with the money earmarked by U.S. District Judge Jimm (CQ) Larry Hendren for Bois d'Arc WMA (\$300,000) and for Project WET (\$100,000).

Other payments included U.S. Treasury (\$50,000), Southern Arkansas University (\$200,000), Arkansas 4-H Foundation (\$50,000) and legal costs and attorneys' fees (\$250,000). The suit was brought by the Arkansas Wildlife Federation and charged Hudson with violating the federal Water Pollution Act with waste discharges from its plant at Hope.

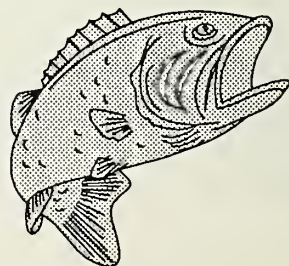
Hendron's order said, "The purpose of the Bois d'Arc, WET, SAU and 4-H projects is to restore, enhance and protect water quality in south Arkansas and in particular the Caney Creek, Bois d'Arc Creek and Red River watersheds downstream of the Hudson (plant) discharge."

Regular reports on all the projects are to be made to the federal court.

## A Look Outdoors

**OCTOBER 16:** Deer Day '93 at the Main Event, 2602 Cantrell, Little Rock. Exhibits and seminars on white-tailed deer.

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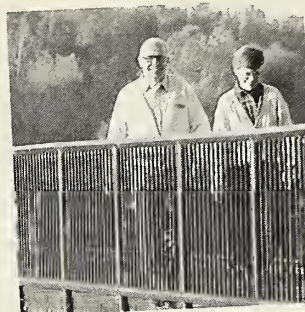
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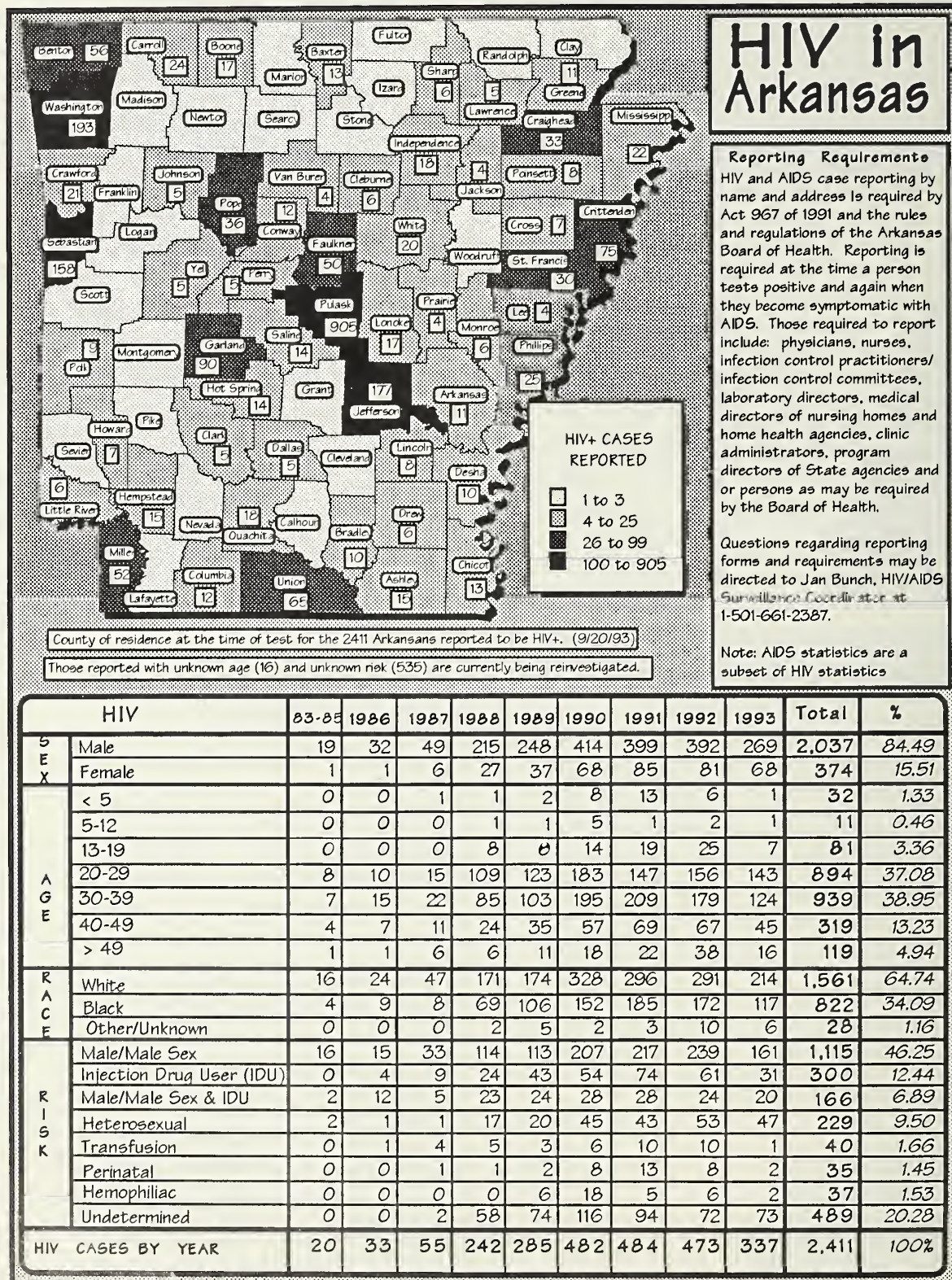
OB/GYN	\$200,000 (Net Guarantee)
FAMILY PRACTICE	\$100,000
PEDIATRICS	\$100,000
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# Arkansas HIV/AIDS Report

## 1983-1993

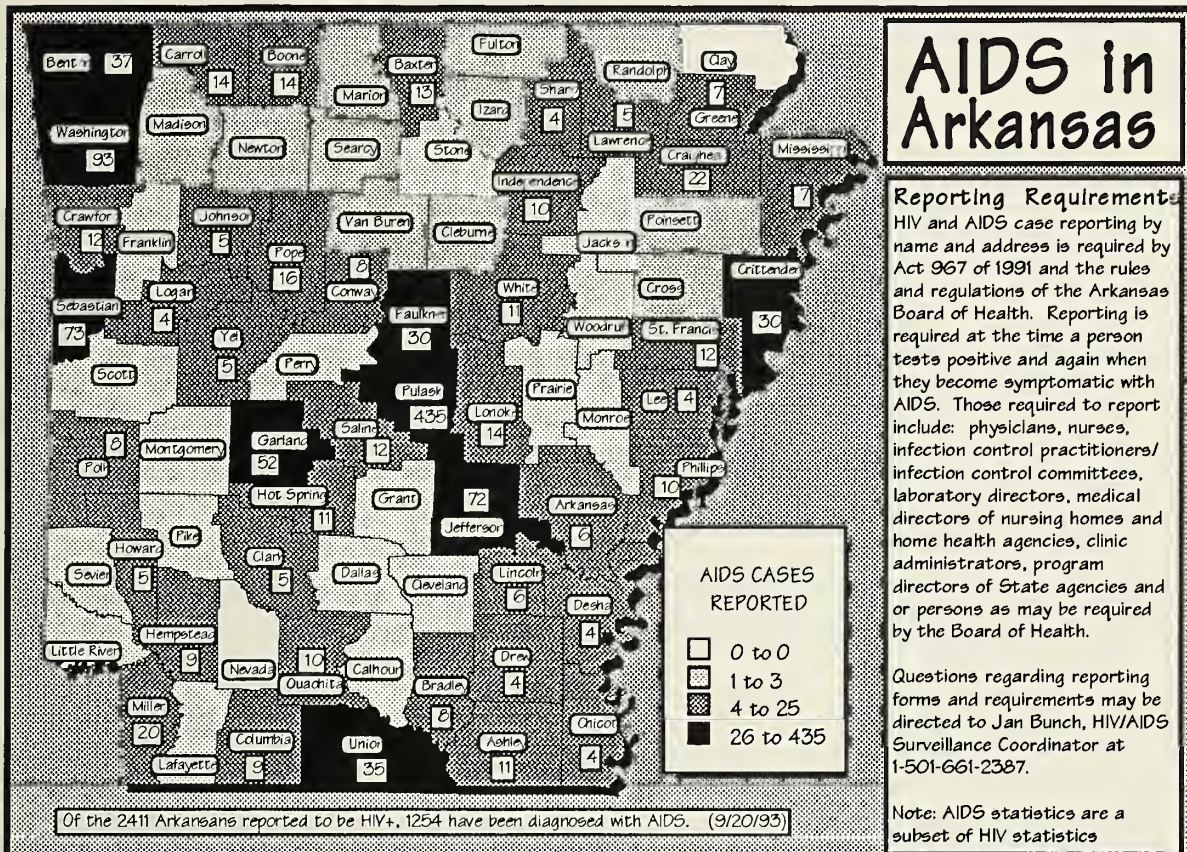


Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1993



AIDS		83-85	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	272	1,100	87.72
	Female	1	0	4	6	10	20	25	35	53	154	12.28
AGE	< 5	0	0	0	1	1	6	6	3	0	17	1.36
	5-12	0	0	0	1	0	1	1	0	1	4	0.32
	13-19	0	0	0	0	0	4	3	2	4	13	1.04
	20-29	7	9	15	27	24	55	57	81	88	363	28.95
	30-39	3	13	23	36	41	78	80	128	146	548	43.70
	40-49	1	6	0	10	7	35	41	52	63	223	17.78
	> 49	1	0	4	8	7	11	13	19	23	86	6.86
RACE	White	9	22	43	61	58	141	134	207	226	901	71.85
	Black	3	6	7	20	21	47	66	74	95	339	27.03
	Other/Unknown	0	0	0	2	1	2	1	4	4	14	1.12
RISK	Male/Male Sex	7	17	31	59	50	120	120	178	177	786	62.68
	Injection Drug User (IDU)	0	2	10	4	11	18	29	43	20	137	10.93
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	47	128	10.21
	Heterosexual	2	0	2	3	6	10	9	25	35	92	7.34
	Transfusion	0	0	2	7	3	7	11	3	2	35	2.79
	Perinatal	0	0	0	1	1	6	6	3	1	18	1.44
	Hemophiliac	0	0	0	1	1	5	5	4	5	21	1.67
	Undetermined	0	0	1	2	2	6	4	11	38	74	5.90
AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	325	1,254	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# New Members

---

## ARKADELPHIA

**Teed, Frank S.**, Ophthalmology. Medical education, UAMS, 1983. Internship/Residency, UAMS, 1990. Board certified.

## FAYETTEVILLE

**Churchill, David A.**, Cardiology. Medical education, UAMS, 1985. Internship/Residency, UAMS, 1988. Fellowship, Baylor College of Medicine, Houston, 1993. Board certified.

**Dollins, Stephen C.**, Psychiatry. Medical education, UAMS, 1989. Internship, University of Pittsburgh, 1990. Residency, Western Psychiatric Institute and Clinic, 1993.

**Long, Robert M.**, Child & Adolescent Psychiatry. Medical education, University of Texas Medical Branch, Galveston, 1974. Residency, University of Texas Medical Branch, 1977.

**Utke, Maria G.**, General Practice. Medical education, University of North Dakota School of Medicine, 1988. Internship, Fayetteville, Arkansas, 1990.

## FORREST CITY

**Edwards, Carl B.**, OB/GYN. Medical education, East Tennessee State University, James H. Quillen College of Medicine, Johnson City, 1989. Internship, Charity Hospital, 1990. Residency, LSU, 1993.

## FORT SMITH

**Whitaker, John C.**, Pediatrics. Medical education, UAMS, 1986. Internship/Residency, UAMS, 1989. Board certified.

## HOT SPRINGS

**Borland, Judy E.**, Emergency Medicine. Medical education, UAMS, 1978. Internship, UAMS, 1979. Board certified.

**Lennon, Barbara M.**, Pediatrics. Medical education, East Carolina University, Greenville, N.C., 1989. Internship/Residency, East Carolina University/Pitt County Memorial Hospital, 1993. Board eligible.

**Young, Michael J.**, Orthopaedic Surgery. Medical education, University of Texas Health Science Center, San Antonio, 1987. Internship/Residency, Tulane, New Orleans, 1993. Board eligible.

## LITTLE ROCK

**Crowell, Karen**, Family Practice. Medical education, Meharry Medical College, Nashville 1990. Internship/Residency, Meharry Medical College/UAMS,

1993.

**Hopkins, Robert H. Jr.**, Pediatrics & Internal Medicine. Medical education, Medical College of Georgia, Augusta, 1989. Internship/Residency, UAMS, Arkansas Children's Hospital, 1993. Board eligible.

**Luttrell, Rex E.**, General Surgery. Medical education, St. Georges University, Grenada, West Indies, 1983. Internship/Residency, East Tennessee State University, 1993.

**Pollock, Michael M.**, General Surgery. Medical education, UAMS, 1988. Internship/Residency, Chicago Medical School and UAMS, 1993.

**Rogers, Charles G. Jr.**, General Surgery. Medical education, LSU, 1986. Internship/Residency, LSU Affiliated Hospitals, 1991. Board pending.

**Schellhase, Dennis E.**, Pediatric Pulmonology. Medical education, University of Texas Medical Branch, Galveston, 1983. Internship/Residency, Vanderbilt University Hospital, Nashville, 1986. Board certified.

**Stewart, Marguerite R.**, OB/GYN. Medical education, Wayne State University, Detroit, 1985. Internship/Residency, Emory University, Atlanta, 1989. Board certified.

**Yuen, James**, Plastic & Reconstructive Surgery. Medical education, Medical College of Virginia, Richmond, 1985. Internship/Residency, West Virginia University, 1990. Residency, Duke University, 1993. Board certified.

## NORTH LITTLE ROCK

**Chu, Tommy D.**, Anesthesiology. Medical education, UAMS, 1981. Internship/Residency, UAMS, 1987. Board certified.

**Meador, Ann S.**, Occupational Medicine. Medical education, UAMS, 1979. Internship, UAMSC, 1980. Residency, Medical University of South Carolina.

## PINE BLUFF

**Jones, James B. III**, Family Practice. Medical education, UAMS, 1981. Internship, University of Tennessee, Knoxville, 1982. Residency, University of Oklahoma College of Medicine, Oklahoma City/AHEC-Pine Bluff, 1989.

**Pace, Rose A.**, General Practice. Medical education, Chicago Medical School, Chicago, 1978. Internship/Residency, Martin Luther King, Jr. General Hospital, 1980.

**Rook, Michael J.**, General Surgery. Medical education, University of Tennessee, Memphis, 1987. Internship/Residency, Methodist Hospital of Memphis, 1993.



## POCAHONTAS

**Guntharp, George R.**, Family Practice. Medical education, College of Osteopathic Medicine, Oklahoma State University, Tulsa, 1990. Internship/Residency, Tri-City Hospital, Dallas, 1993. Board certified.

## PRESCOTT

**Rodgers, Kenneth F.**, General Practice. Medical education, UAMS, 1988. Internship, Cavanaugh Valley Memorial Hospital, Johnston, Pennsylvania, 1989. Residency, Johnston, Pennsylvania and UAMS, 1991.

## ROGERS

**Bumpers, Paul E. Jr.**, Urology. Medical education, UAMS, 1984. Internship/Residency, UAMS, 1989. Board certified.

**Lanier, Karen A.**, OB/GYN. Medical education, University of Oklahoma, Oklahoma City, 1987. Internship/Residency, LSU, 1991. Board certified.

## RUSSELLVILLE

**Massey, Virgil R.**, Anesthesiology. Medical education, University of Mississippi, Jackson, 1989. Internship, Baptist Memorial, Memphis, 1990. Residency, University of Mississippi, 1993.

## SPRINGDALE

**Ross, Joe G.**, Radiation Oncology. Medical education, UAMS, 1979. Family Practice Residency, Charlotte, North Carolina, 1982. Radiation Oncology Residency, University of Iowa, 1993. Board certified.

## RESIDENTS

**Beasley, Darryl K.**, Anesthesiology. Medical education, UAMS. Internship, Michael Reese Hospital, Chicago, 1993. Residency, University of Illinois/Michael Reese Hospital.

**Bolliger, Karen D.**, Med/Peds. Medical education, University of Oklahoma College of Medicine, Tulsa, 1992. Residency, UAMS.

**Bonin, Thomas C.** Medical education, F. Edward Hebert School of Medicine, Uniformed Services Univ. of Health Sciences, Bethesda, Maryland, 1993. Internship, AHEC-Fort Smith.

**Brandt, John O.**, Internal Medicine. Medical education, UAMS, 1993. Internship, UAMS.

**Buchanan, Grace A.** Medical education, UAMS, 1993. Internship, UAMS.

**Carroll, Barry S.**, Family Practice. Medical education, UAMS. Internship/Residency, AHEC-Northeast.

**Daniels, Rebecca J.** Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1993.

**De Palo, Loretta**, Emergency Medicine. Medical

education, UAMS, 1990. Internship/Residency, UAMS.

**Evans, Samuel C.**, Family Practice. Medical education, UAMS, 1991. Internship/Residency, UAMS.

**Froman, Elizabeth A.**, Pediatrics. Medical education, UAMS, 1993. Residency, UAMS/Arkansas Children's Hospital.

**Grant, Jerry H.** Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1993.

**Heard, Adele B.**, Pediatrics. Medical education, UAMS, 1993. Internship, UAMS/Arkansas Children's Hospital.

**Hughes, J. Martin**, Internal Medicine. Medical education, UAMS, 1993. Internship, UAMS.

**Isnard, Donna M.**, Family Practice. Medical education, University of Kansas, Kansas City, 1993. Residency, AHEC-Fort Smith.

**Jain, Parker K.**, Family Practice/ER. Medical education, West Virginia School of Osteopathic Medicine, Lewisburg, 1991. Internship, Jeffer Regional Medical Center, AHEC Central, 1992.

**Jazieh, Abdul Rahman**, Internal Medicine. Medical education, Damascus University, Damascus, Syria, 1988. Internship/Residency, St. Francis Hospital of Evanston, Evanston, Illinois, 1993. Fellowship, UAMS.

**Lee, Remington**, Physical Medicine & Rehabilitation. Medical education, Texas College of Osteopathic Medicine, Fort Worth, 1991. Internship, Dallas Memorial Hospital, 1992. Residency, UAMS.

**Lum Cheong, Ronnie S.**, General Surgery. Medical education, Howard University College of Medicine, Washington, D.C., 1989. Internship/Residency, Howard University Hospital. Fellowship, Arkansas Children's Hospital.

**Maddox, Randolph P.**, Emergency Medicine. Medical education, UAMS, 1991. Internship, UAMS, 1992. Residency, UAMS.

**Medlock, Jeff A.**, Family Practice. Medical education, University of Texas Medical School, San Antonio, 1993. Residency, AHEC-Fort Smith.

**Roberts, Cathy L.**, Anesthesiology. Medical education, Oklahoma University College of Medicine, Oklahoma City, 1990. Internship/Residency, Oklahoma University College of Medicine, Oklahoma City, 1993. Residency, UAMS.

**Sanders, Kelli K.**, Family Practice. Medical education, UAMS, 1993. Internship, UAMS.

**Verbois, Glennal M.**, Transitional/Physical Medicine & Rehabilitation. Medical education, LSU, 1993. Internship, UAMS.

**Walker, Barry A.**, Family Practice. Medical education, UAMS, 1993. Internship/Residency, AHEC-Fort Smith.

**Wooten, Marc D.**, Internal Medicine. University of Texas Southwestern Medical School, Dallas, 1988. Internship/Residency, Good Samaritan Regional Medical Center, 1992. Fellowship, UAMS.

## STUDENTS

Tracy C. Baltz  
John H. Barrow  
Judith A. Bynum  
Randall D. Carlton  
Timothy L. Cramm  
Minh-Nhut Y. Dang  
James E. Darr  
Larry C. Graham  
Martha D. Green  
Mary E. Groves  
John E. Harris  
Christina A. Jetton  
Jill D. Johnson  
Rita J. Keith  
Gregory W. Mallard  
Elizabeth B. Nelson  
Becky A. Nowell  
Keane T. O'Neal  
Tracy L. Rowe  
Julie A. Shiflett  
Thomas P. Stern  
John C. Webber  
Michael N. Wiggins

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## YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

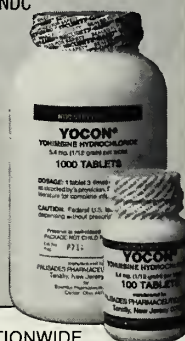
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



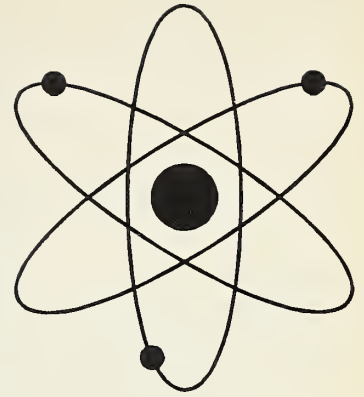
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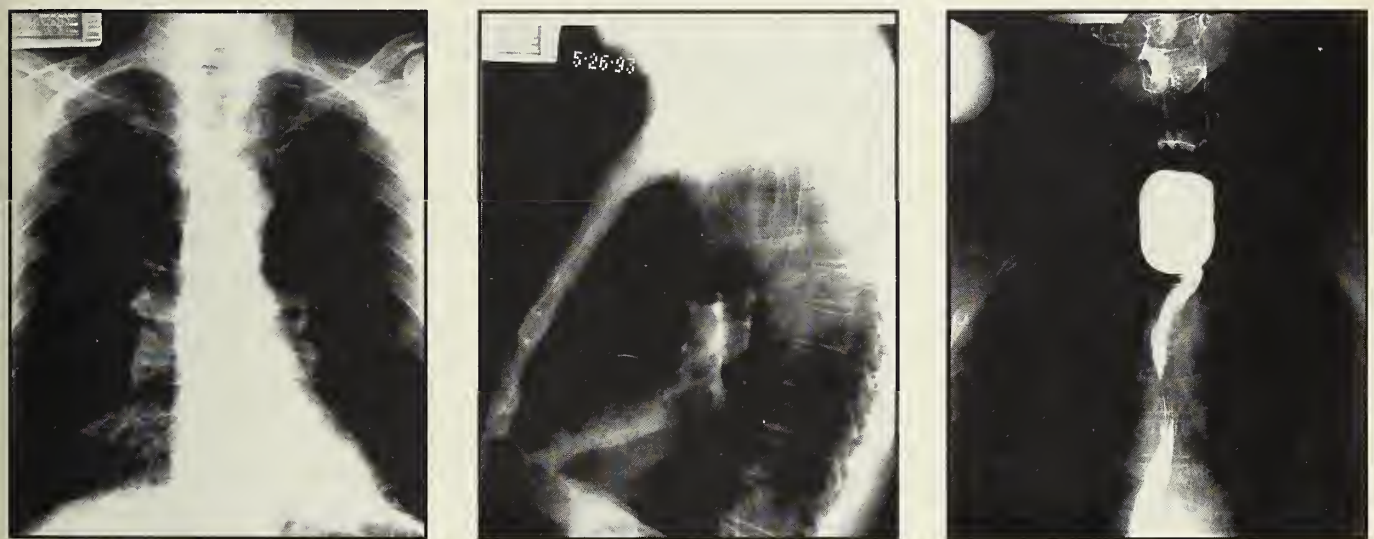
# Radiological Case of the Month



Steven R. Nokes, M.D.  
Robert M. Searcy, M.D.  
Adrian Williamson, III, M.D.  
W. Bradley Pierce, M.D.

## History:

This 74-year-old male presented with a cough and dysphagia. A chest x-ray, barium swallow and CT scan of the chest were performed.



*Figure 1a (above left) and 1b (above center):  
PA and lateral chest  
Figure 2 (above right): Barium swallow  
Figure 3 (right): CT scan of the chest.  
The masses measure -63 HU.*



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# Lipoid pneumonia.

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## Findings:

The PA and lateral chest reveals two areas of mass-like consolidation in the left lower lobe and right middle lobe. A fluid level can be seen in the hypopharynx in the patient's Zenker's diverticulum. The barium swallow confirms a large Zenker's diverticulum. The CT scan demonstrates two well-circumscribed low density mass lesions in the RML and LLL. The density measurements are consistent with fat (-60 to -160 Hounsfield units).

## Discussion:

Exogenous lipid pneumonia results from aspiration of oil and was first described in 1925. Neuromuscular and structural abnormalities of the esophagus and pharynx (diverticula, achalasia and reflux) are predisposing factors. Mineral oil is the most common offending agent as it both fails to elicit a cough reflex and impairs ciliary motility. Our patient took mineral oil each evening for constipation.

The pathology of lipid pneumonia due to aspiration of mineral and vegetable oils is a simple foreign body reaction in the lung. Animal oils produce a necrotizing hemorrhagic pneumonia due to a higher free fatty acid content. Mineral oil is emulsified by macrophages and transported in the interstitium. As the process matures septa are destroyed and thickened. Finally the normal lung architecture is replaced by a pool of oil surrounded by a giant cell foreign body reaction.

Roentgenographically, the typical pattern involves alveolar consolidation. In the later stages ill-defined mass lesions are evident, usually in the lower lobes, but occasionally in the middle lobe and lingula. CT is definitive in demonstrating diminished attenuation within the mass. Prior to CT the diagnosis required aspiration or surgical biopsy.

## References

1. Kennedy JD, Costello P, Balikian JP, Herman PG. Exogenous lipid pneumonia. *AJR* 1981; 136: 1145-1149.
2. Lipinski JK, Weisbrad GL, Sanders DE. Exogenous lipid pneumonitis: pulmonary patterns. *AJR* 1981; 136: 931-934.
3. Wheeler PS, Stitik FP, Hutchins GM, Klinefeller HF, Siegelman SS. Diagnosis of lipid pneumonia by computed tomography. *JAMA* 1981; 65-66.

---

*Editor: Steven R. Nokes, M.D., is affiliated with Radiology Consultants in Little Rock.*

*Contributor: Robert M. Searcy, M.D., is affiliated with the Little Rock Diagnostic Center.*

*Contributor: Adrian Williamson, III, M.D., is affiliated with The Affiliated Ear Nose and Throat Clinics of Arkansas.*

*Contributor: W. Bradley Pierce, M.D., is affiliated with Radiology Consultants in Little Rock.*



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**Arkansas Medical Society**  
**Political Action Committee**

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While regular mammograms are important for women over 40, the risk of breast cancer increases with age, so it becomes critically important that all women over 50 have a mammogram every year.

Annual mammography is crucial for early detection and intervention—it is a woman's only true protection. Yet too many women are not hearing this message.

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EVERY YEAR AFTER 50



# AMS Newsmakers

**Dr. Robert W. Arrington** was recently elected Chief of Staff at Arkansas Children's Hospital in Little Rock. **Dr. Glen F. Baker** was elected Vice-Chief of Staff.

**Dr. Hal Bienvenu** has completed a year-long fellowship in cosmetic surgery sponsored by the American Academy of Cosmetic Surgery, and has passed the written portion of the national board exams administered by the American Board of Cosmetic Surgery. He is opening an office in Little Rock, where he will practice cosmetic and facial plastic surgery and otolaryngology.

**Dr. R. Jay Mullis**, of Fayetteville, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Washington Regional Medical Center. **Dr. Joseph G. Ross**, of Springdale, received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at North Arkansas Radiation Therapy Institute. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

These physicians are among a national network of over 2,000 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities.

**Dr. Lee Parker**, director of AHEC-Northwest in Fayetteville, recently was honored by the Arkansas Academy of Family Physicians as the 1993-94 Arkansas Family Doctor of the Year.

**Dr. Gail Ray**, chairman of the Department of Emergency Medicine at the University of Arkansas for Medical Sciences Medical Center in Little Rock, was recently elected to a two-year term on the Nominating Committee of the Society of Academic Emergency Medicine.

**Dr. J. Wayne Smith** of Hot Springs has been elected to Fellowship in the American College of Physicians, the professional organization of internists. Smith is affiliated with Arkansas Nephrology Services.

**Dr. Paul Wills**, an otolaryngologist associated with Western Arkansas Ear, Nose, Throat and Allergy Clinic, has been appointed to the Board of Trustees of St. Edward Mercy Medical Center.

**Dr. James E. Zini**, a board certified osteopathic family physician in Mountain View, was re-elected to a second three-year term on the board of trustees of the American Osteopathic Association (AOA) at the recent AOA House of Delegates meeting held in Chicago.

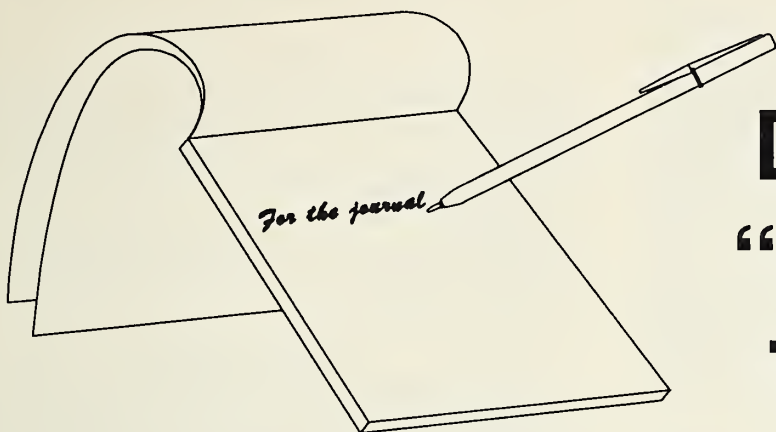
## Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of August are:

Leslie F. Anderson	Lonoke	Fernando Padilla	Little Rock
Joe L. Buford	North Little Rock	James J. Pappas	Little Rock
Thomas D. Cain	Little Rock	Dac Tat Pham	Brinkley
James W. Campbell	Hot Springs	William V. Relyea	Cherokee Village
William L. Diacon	Bella Vista	Rickey O. Ryals	Jonesboro
Marlon J. Doucet	Little Rock	Terri Y. Schweitzer	Jonesboro
Stevenson Flanigan	Little Rock	Leonus L. Shedd	Paragould
Benjamin H. Hall	Lincoln	Joseph F. Shotts	Cabot
Kathryn D. Hendrickson	Fort Smith	Mose Smith	Little Rock
Robert E. Holder	Bentonville	Alan R. Storeygard	Jacksonville
John A. Huskins	Rogers	Don B. Vollman	Jonesboro
Richard D. Jennings	Jonesboro	Paul A. Wallick	Monticello
Paul C. Kramm	Sherwood	James R. Weber	Jacksonville
Robert H. Langston	Harrison	Joseph T. Wilson	Jonesboro
William R. McKiever	Monticello		

*The American Medical Association does not maintain a central file of the reported Continuing Medical Education (CME) activities of physicians who have applied for the Physician's Recognition Award. No copy of the application is maintained in our file, which contains only the record that you have been awarded the PRA certificate and the date of the certificate. It is recommended that each physician maintain an individual file of continuing medical education activities and awards.*





# DO THE "WRITE" THING!

We are always looking for interesting and informative articles for *The Journal of the Arkansas Medical Society*. *The Journal* is a good way to pass an experience you have had or important information you have learned on to your fellow medical professionals. If you would like to consider being an author for *The Journal*, below is a list of topics our readers would be interested in. Or if you have another topic that you think would be of interest to your peers, please submit it for consideration.

- Enhancing the doctor-patient relationship
- Practice management for today's physicians
- Women's health issues
- Teens and drug use
- A smokeless society
- Medical ethics and health care
- What's the value of organized medicine?
- New treatments and technology
- Physicians and managed care
- Physician stress, emotions, health
- Medicare/Medicaid issues
- Medical history of Arkansas
- A doctor's hobby
- Medicine of the future
- Improving the physician's image
- How to market your practice
- New treatments from Arkansas' medical facilities
- Coping with difficult patients

For more details, call or write:  
Cindy Sawrie  
Managing Editor  
The Journal of the Arkansas Medical Society  
P.O. Box 5776  
Little Rock, AR 72215  
(501) 224-8967 • (800) 542-1058

## Health Care Access Foundation Update

As of September 1, 1993, the Arkansas Health Care Access Foundation has provided free medical service to 6,418 medically indigent persons, received 12,420 applications, and enrolled 25,362 persons.

The program has 1,642 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

## Health Insurers Report Increase in Fraud Cases

The number of fraud cases investigated by health insurance companies increased by more than 75 percent in the last two years, while net savings from fraud investigations increased by 150 percent, according to a survey on anti-fraud activities released today.

The increase in investigations for caregivers that tracked both their total savings from these investigations and anti-fraud budgets resulted in savings of \$112 million in 1992, with a cost/benefit ratio of 1 to 9, up from 1 to 7 in 1991 and 1990, reports the Health Insurance Association of America (HIAA). Health insurance companies responding to the survey investigated 26,755 fraud cases last year - up from 15,246 in 1990.

HIAA found that 79 percent of insurers responding to the survey have developed health care anti-fraud programs.

"The savings from anti-fraud activities are significant and warrant the insurance industry's continued vigilance," said HIAA president Bill Gradison. "This is one proven way we can work to contain health costs."

Provider fraud constituted two-thirds of the fraudulent health care claims in 1992, according to health insurers polled in the survey. Consumer fraud consisted of one-third.

The survey found that 43 percent of those cases reported as provider fraud in 1992 were the result of fraudulent diagnoses or dates, 34 percent were provider billing for services not rendered, 21 percent were provider waiving co-payments and deductibles, and 2 percent were other types of provider fraud.

Of those cases reported as consumer fraud in 1992, 40 percent were from falsifying claims, 25 percent were false records of employment and eligibility, 5 percent were fraudulent misrepresentation in applications, and 30 percent were other types of consumer fraud.

Eighty-six companies, representing large, medium, and small health insurers, responded to the HIAA 1993 survey on health care anti-fraud activities. These 86

companies consisted of 79 commercial insurers representing 65 percent of the commercial market and seven Blue Cross/Blue Shield plans representing 14 percent of the BCBS market.

HIAA is a Washington, D.C.-based trade association representing the nation's leading commercial health insurance companies.

## Call for Papers

The International Conference on Physician Health, to be held September 14-18, 1994 in Ottawa, Ontario, Canada is accepting abstracts addressing topics related to physician health, including AIDS, HIV, problems related to aging, mental illness, substance abuse, and physical disabilities and limitations, including those caused by general medical conditions. Possible topics for presentation include presentation and treatment of health problems among physicians, the impact of disorders on physicians' families and practices, medical-legal issues facing hospital administrations and licensing boards, and material on health promotion and disease prevention. Abstracts which address issues related to these topics (i.e., prevention, diagnosis, treatment, rehabilitation), but not dealing specifically with physicians are also welcome. Submission Deadline: February 1, 1994. Contact Elaine M. Tejcek, Department of Mental Health, American Medical Association, 515 N. State Street, Chicago, IL 60610, (312) 464-5073.

## CHAMPUS Expands Partial Hospitalization to Include Mental Health Treatment

CHAMPUS has broadened its coverage of partial hospitalization beyond alcoholism rehabilitation, to include other psychiatric disorders.

The expanded benefit will be effective for care provided in CHAMPUS-authorized partial hospitalization programs on or after September 29, 1993. It will be limited to 60 days of treatment per government fiscal year (Oct. 1 through Sept. 30), with waivers available for unusual cases. Each partial day counts as one day toward the 60-day limit.

The partial hospitalization benefit for alcoholism rehab will remain at its previous limit of 21 days per 365-day period.

Pre-admission and continued-stay authorizations are required for all admissions to a partial hospitalization program (including alcoholism rehab). In most parts of the country, CHAMPUS' mental health contractor, Health Management Strategies International, Inc. (HMSI), will review and authorize all partial hospi-



talization care before admission, and will also review the care while it is being provided. In certain areas, such as in California and Hawaii; New Orleans; the Norfolk, Virginia area; and several additional sites in Texas and Louisiana, the CHAMPUS contractor for those areas will handle advance authorization. Contact the Health Benefits Advisor at the nearest military medical facility for information and assistance.

Facilities wishing to treat patients under CHAMPUS may be free-standing or hospital-based. They must comply fully with CHAMPUS standards, must be certified by HMSI as institutional providers for partial hospitalization programs, and must enter into a participation agreement before admitting CHAMPUS patients.

Claims for care must be submitted on the UB-82 or UB-92 claim forms, and the claim must identify the number of hours of care actually provided. Providers may not bill CHAMPUS patients for charges in excess of the cost-share, for days the patient is absent, or for services that CHAMPUS won't pay for because the provider didn't comply with requirements for pre-authorization or concurrent care review.

CHAMPUS will reimburse psychiatric partial hospitalization programs based on fixed regional per diem rates. Reimbursement is all-inclusive; it covers patient assessment, psychological testing and assessment, treatment services, board, ancillary services, etc.

The only services that may be billed separately are individual or family psychotherapy (up to five sessions per week) provided by a CHAMPUS-authorized professional provider who is not employed by, or under contract with, the partial hospitalization program, and non-mental-health-related services not normally included in the evaluation and assessment of a partial hospitalization patient.

Professional providers who bill separately for individual or family psychotherapy must state on the claim form that the psychotherapy is related to a partial hospitalization stay. Otherwise, the claim will be denied, since outpatient psychotherapy is not authorized during the time a patient is participating in a partial hospitalization program.

For more information about the program, call HMSI at (800) 242-6764.

# Resolution

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## William W. Christeson, M.D.

Whereas, the recent death of William W. Christeson, M.D., an esteemed member of this Society, is noted with sincere sorrow; and

Whereas, he was a loyal member of this organization for over forty years; and

Whereas, Dr. Christeson's devotion to his patients and his profession is recognized with appreciation; be it therefore

*RESOLVED*, that this resolution be adopted and placed in the permanent records of this Society; and

*RESOLVED*, that a copy of this resolution be sent to Dr. Christeson's family as an expression of our heart-felt sympathy; and

*RESOLVED*, that a copy be forwarded to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
August 18, 1993

By Order of the Memorials Committee  
Bruce E. Schratz, M.D., Chairman  
Robert Watson, M.D.

# In Memoriam

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## James W. Webb, M.D.

Dr. James W. Webb, of Jonesboro, died Wednesday, August 18, 1993. He was 76.

Survivors are his wife, Barbara Webb; daughter, Candace Franks of Little Rock; 1 son, Dr. James P. Webb; 2 sisters; 3 grandchildren.



# Things To Come

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## November 3

**4th Annual Rush Symposium on Transplantation.** Rush-Presbyterian-St. Luke's Medical Center. Fee: \$100 and \$75 for fellows and post-doctoral students. For more information, call (312) 942-6242.

## November 4-7

**12th Annual Scientific Meeting of the American Pain Society.** Buena Vista Palace, Orlando, Florida. For further information, contact Cynthia Porter at The American Pain Society, (708) 966-5595.

## November 5-7

**Fifth Annual Infectious Disease Review Course for the Practicing Physician.** Hyatt Regency Bethesda, Maryland. Sponsored by the Center for Bio-Medical Communication. Category I credit: 17.5 hours. For more information, call (201) 385-8080 or (800) 231-0389.

## November 11-14

**40th Annual Meeting of the Academy of Psychosomatic Medicine.** The Fairmont Hotel, New Orleans. For more information, call (312) 784-2025.

## November 12-14

**Anesthesiology Update: 1993.** Monterey Plaza Hotel, Monterey, California. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine and Medical Center. Category I credit: 14 hours. For more information, call (916) 734-5390.

## November 13

**Updated Neurology for the Primary Care Physician.** UC Davis Medical Center, Cancer Center Auditorium, Sacramento, California. Sponsored by Office of CME. Approximately 8 hours Category I credit. For more information, call (916) 734-5390.

## November 14-18

**97th Annual Meeting of The American Academy of Ophthalmology.** McCormick Place, Chicago. For more information, call The American Academy of Ophthalmology Meeting Department at (415) 561-8500.

## November 17-19

**Contemporary Cardiothoracic Surgery.** The Ritz-Carlton Hotel, St. Louis, Missouri. 21.5 Category I credit offered. For more information, contact the Office of CME at Washington University School of Medicine, (800) 325-9862.

## November 19-20

**3rd Annual Pain Management Conference.** Silverado Country Club, Napa, California. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For information, call (916) 734-5390.

## November 20

**Hypercholesterolemia Seminar.** Marriott Pavilion, St. Louis, Missouri. For more information, call the Office of CME, Washington University School of Medicine at (800) 325-9862.

## December 3

**Women's Healthcare Issues '93.** The Ritz-Carlton Hotel, St. Louis, Missouri. For more information, call the Office of CME, Washington University School of Medicine at (800) 325-9862.

## December 4

**GI Update.** The Ritz-Carlton Hotel, St. Louis, Missouri. For more information, call the Office of CME, Washington University School of Medicine at (800) 325-9862.

## December 9-11

**Women: Face to Face with HIV.** Sponsored by the Delta Region AIDS Education and Training Center, with the National Institutes of Health and others. For information, call Daphne LeSage at (504) 568-3855.

## December 11

**Cardiology Seminar.** The Ritz-Carlton Hotel, St. Louis, Missouri. For more information, call the Office of CME, Washington University School of Medicine at (800) 325-9862.

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Conference fee for meeting facilities and food service—AMA members \$50, nonmembers \$125. MasterCard, Visa, American Express, Optima are accepted.

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# Keeping Up

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## Update in Primary Care Geriatrics - 3 Part Series (Parts 2 & 3)

October 30 & November 13, Baker Conference Center, Washington Regional Medical Center. This conference, sponsored by Washington Regional Medical Center, was divided into 3 sessions (two remaining) to be held on the Saturday of each Razorback football home game in Fayetteville. Continental breakfast will be served. Fee: \$15. R.S.V.P. by calling the continuing medical education department at 442-1823. Category I credit: 2 hours per session.

## Primary Care Update 1993

October 22, registration at 7:30 a.m., will adjourn at 4:45 p.m., Baptist Medical Center, J.A. Gilbreath Conference Center, Little Rock. Presented by Baptist Medical Center, Medical Affairs. Category I credit: 6 hours. Registration fee: \$90 for physicians; \$40 for nurses and other medical personnel before October 8. After October 8, \$115 - physicians; \$50 - others.

## 1993 Arkansas Physicians Opportunity Fair

October 28, 10:00 a.m.-3:00 p.m., Jeff Banks Student Union at UAMS, Little Rock. For information, call Tom G. South, (501) 686-5813.

## Tenth Annual Conference on Perinatal Care

November 4-5, time to be announced, Excelsior Hotel, Little Rock. Sponsored by UAMS College of Medicine and presented by Dr. J. Gerald Quirk. Category I credit to be announced.

## Ultrasound Update 1993

November 6-7, UAMS, Educational Bldg. II, Room G131A/B, Little Rock. Sponsored by the Arkansas Chapter of the American College of Radiology and the Office of Continuing Education for Physicians at UAMS. Cat-

egory I credit: 7 hours. Fee: \$100-physicians; \$50-technologists. For information, call (501) 663-2244.

## Diagnosis and Treatment of Active Duodenal Ulcer

November 18, 12:00 p.m.-1:30 p.m., Medical Center of South Arkansas, Conference Room 3, El Dorado. Presented by Dr. Fred M. Sutton, Gastroenterology, Baylor, and sponsored by AHEC-South Arkansas. Category I credit: 1 hour.

## Surgery for Cleft Lip and Cleft Palate

November 18-21, time to be announced, Arkansas Children's Hospital Conference Center, Little Rock. Sponsored by UAMS College of Medicine and presented by Dr. Robert Seibert. Category I credit offered: 17.25 hours.

## Infectious Disease

December 9, 12:00 p.m.-1:30 p.m., Medical Center of South Arkansas, Conference Room 3, El Dorado. Presented by Dr. Terry Yamauchi, UAMS Outreach Program and sponsored by AHEC-South Arkansas. Category I credit: 1 hour.

## Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

### FAYETTEVILLE-VA MEDICAL CENTER

Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

### HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, Oct. 22, Nov. 12, Dec. 10, 12:30 p.m., AMI Ozark - Quapaw Room



## **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar*, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
*Genetics Conference*, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
*Infectious Disease Conference*, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
*Pediatric Grand Rounds*, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
*Pediatric Neuroscience Conference*, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
*Pediatric Pharmacology Conference*, 5th Wednesday, 12:00 noon, 2nd Classroom  
*Pediatric Research Conference*, 1st Thursday, 12:00 noon, 2nd Floor Classroom

## **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
*Journal Club*, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Chest Conference*, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Hematology-Oncology Conference*, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Cancer Center Team Conference*, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

## **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*Breast Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*GI Conference*, 4th Friday, 11:30 a.m., Conference Room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
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*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
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*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

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*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas



*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

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*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
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*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Harris Hospital Tumor Conference*, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

#### **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff Country Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

#### **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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# What Happened to Physician's Payment Reform Under Medicare?

James R. Weber, M.D.

The Resource Based Relative Value System (RBRVS) of physician payment reform was implemented in 1992 under the Medicare Program. We recognize that physicians' payment reform under Medicare did not turn out as Congress had planned. Nor did it turn out as its creator, Dr. Hsiao, envisioned, and certainly not as the Health Care Finance Administration predicted. Most primary care physicians have not seen any appreciable increase in payments for office services. In almost all parts of the country, Medicare reimbursement remains below the cost of providing office visits. Access to care has become a major problem for senior citizens in many states, including Arkansas. The payment below the cost simply amounts to a hidden tax. Ironically, in Medicare this is levied against those physicians who are the primary care givers to the elderly. Recent studies have shown that this amounts to more than most primary doctors pay in income tax. It would be unconscionable for any government, state or federal, to put a provider tax on top of that.

The primary physicians for senior citizens are for the most part, family physicians and general internists. Approximately 90% of the payments made to these physicians under the Medicare program are for office visits. Now that physician payment reform under Medicare has ended up with a fee schedule that still pays less than the cost of providing office visits, people are wondering how that could have happened when the

major purpose was to correct this inequity. This has perpetuated a major problem of access to care for those very citizens in our society who are most in need of medical care.

Let me give you some specifics. The following table compares the Medicare fee schedule in Arkansas with the Blue Cross Blue Shield fee schedule and the Physician's Fee Guide Reference of Health Care Consultants of America, Inc. for office visits for the established patient:

	Procedure Code	Arkansas Medicare Fee Schedule	Arkansas BlueCross BlueShield Fee Schedule	Physicians Fee Guide - HealthCare Consultants of America, Inc.
Established Patient - CPT-4				
*face to face	99211 aprx 5 min	11.43	18.00	24.00 - 32.00
*face to face	99212 aprx 10 min	18.20	34.00	36.00 - 45.00
*face to face	99213 aprx 15 min	23.26	44.00	46.00 - 58.00
*face to face	99214 aprx 25 min	43.95	87.00	70.00 - 87.00
*face to face	99215 aprx 40 min	68.89	145.00	112.00 - 151.00
*Pre and post time of visit not included.				

Of the Medicare fee schedule listed above, the patient pays 20% and Medicare pays 80%. Recent practice cost studies have shown that the average cost per hour to operate the office of a full service primary care physician runs between \$120 and \$180 per hour, per physician. The cost of providing these services in many family physician and general internists' offices in Arkansas may be even higher than this nationwide average, particularly in rural areas. One can readily see from these figures that it is virtually impossible to cover the



expense of providing office visits to our Medicare patients.

It is now well-established that if 30% of a primary care physician's patients are Medicare, approximately 50% of the visits will be by Medicare patients. These have become critical numbers for a practice to remain financially viable. It has become a national tragedy that most primary care physicians will not be able to financially survive if they take on greater loads of Medicare patients.

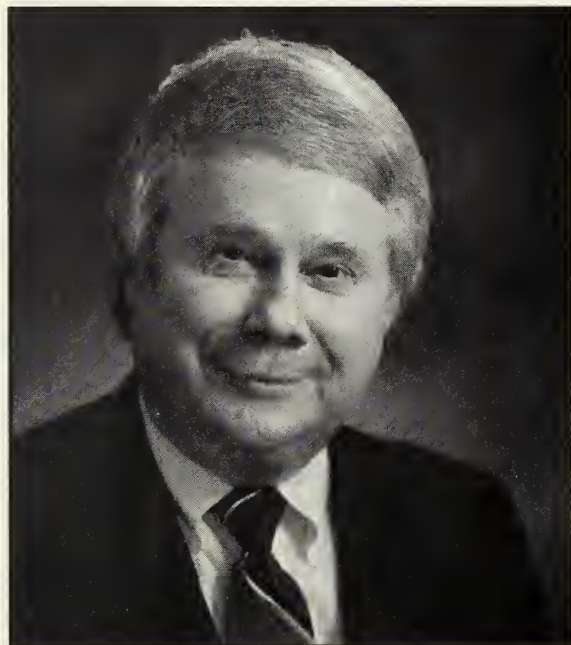
According to Dr. Hsiao in the New England Journal of Medicine, April 1993, if all payors use the Medicare fee schedule today, pediatricians would earn \$35,000; family physicians \$40,000; and general internists \$44,000 per year. Many young primary care physicians would not live long enough to repay their medical school debts, would they? Dr. Hsiao concluded that the misallocation of practice expenses in the Medicare fee schedule results in serious underpayment for medical services. He believes that the current conversion factor produces unreasonably low levels of payment overall.

In his article in the July 1993 issue of Family Physician, Dr. Martin Proudfoot concluded that if the present Medicare fee schedule were adopted by all payors, the one payor system, Medicare for all, the average income of a family physician by the year 2000 would be 0, and I agree.

It should be emphasized that the Clinton Health Reform Plan has outlined specific measures to try to correct this inequity. Specifically the Clinton plan would eliminate office consultations and spread this increased payment over all office visits. He would increase the relative value for work and for practice costs by approximately 10% each. He would implement a resource based practice cost relative value which would take three to five years to develop. They would exempt primary care from the cut in the conversion factor proposed two years down the road. These changes would benefit primary care reimbursement. Unfortunately, these gains are, for the most part, neutralized by the budget cuts in Medicare over the five year period and reimbursement for primary care office services would end up about the same level as today.

Payment below the cost of providing services by Medicare and Medicaid is a major uncompensated care factor in today's healthcare system. Russell Harrington, Chairman of the Board of the Baptist Medical System, has stated that forty cents on the dollar of every Arkansas hospital bill is due to cost shifting because of underpayment by the Medicare and Medicaid program. This is a major factor in driving the cost of health insurance in the private sector up to the point where it is unaffordable by individuals, small businesses and American industry, which competes worldwide. If we are going to have meaningful health care reform, this problem must be addressed and corrected.

*The  
Arkansas Medical Society  
would like to congratulate  
Dr. Weber for his recent  
election as President-Elect of the  
American Academy of Family Physicians*



**James R. Weber, M.D.**

While maintaining an active family practice for over 32 years, Dr. Weber has been involved with the Arkansas Academy and The American Academy of Family Physicians for many years. He has chaired the AAFP's Committee on Scientific Program and the Health Care Services Commission. In 1990, he was elected to the Board of Directors of the American Academy and for the past year has served as Chairman of the Board.

Dr. Weber has also been an outstanding member of the Arkansas Medical Society for more than 30 years. He served as Chairman, Legislative and Governmental Affairs and Lobbyist, 1979-1989. He has been a member of the Governing Board since 1979. He served as Secretary, 1979-1989, and he was President of the Arkansas Medical Society, 1989-1990. Beginning in 1994 he will be a Delegate to the American Medical Association.



Basically, the primary care physicians of Arkansas have taken on loads of new Medicare patients to the point where many of their practices are now in very much of a survival mode, hoping that the problem of under-reimbursement will be corrected with health care reform. Most of these physicians are already working 60 to 80 hours per week, twice that of the average American worker, and would be unable to see more patients. Obviously, when you think about it, when one is reimbursed at a rate less than the cost of providing a service, there is no way to make it up on volume. Reimbursement below the cost of providing office visits by both Medicare and Medicaid has been one of the major disincentives for medical students to enter primary care specialties and to practice in rural areas like Arkansas. It is understandable why many of these physicians are leaving practice and going into emergency medical care, going to work for the VA, moving to other states, taking jobs with closed panel HMOs, or going into administration. This problem threatens the very fiber of health care delivery in a rural state like Arkansas, and must be corrected. All major health care reform proposals have primary care physicians as the infrastructure for the future.

It is interesting to analyze briefly exactly what happened in RBRVS Physician Payment Reform for Medicare.

Basically it has failed because it was used by the government primarily for budget cutting.

The many predictions of HCFA of improved reimbursement for office visits were based primarily on estimates of the historic based charges, which in many instances proved to be incorrect when they were actually calculated, and therefore were way off.

Dr. Hsiao's work at Harvard developed only the relative values for the work portion of the formula. I was one of the one hundred physicians who participated in this research project. The relative values developed for work were very statistically sound and reproducible. The RBRVS formula, however, not only includes the relative values for work, but also computes a relative value for practice cost and one for professional liability costs. These parts of the formula are seriously flawed and were used for budget cutting. As Dr. Hsiao has stated, the conversion factor was unreasonably low. It was then further lowered by a behavioral offset factor that has now been proven wrong. This hurt the physicians most that were intended to be helped by RBRVS.

In addition, approximately 240 of the most commonly used procedures were identified and inappropriately called "over reimbursed procedures" by Medicare. These were the most expensive and amounted to the greatest financial outlay. Reimbursement for these procedures was lowered 15% in the year 1990, and then lowered another 15% in the year 1991. When RBRVS

was instituted in the year 1992 (in a budget neutral manner), reimbursement for these procedures was further lowered by another 15 to 25%. That is why surgery is now reimbursed by Medicare at about 50% of the amount before RBRVS payment reform. By the time the RBRVS was instituted in the year 1992, the total amount of money available for payment of physician's services had been markedly decreased. The government strategy seemed to be to markedly shrink the amount of money available for Medicare reimbursement to physicians prior to the budget neutral implementation, which to a great extent has created much of the problems that we face today.

For the sake of the senior citizens of this country and for all of the physicians who truly care about them and who provide their medical care, these problems must be corrected if we are to have meaningful health care reform. The public has an image that perceives physicians as being wealthy, and some are. I can assure you today that if your personal physician is a family physician, general internist or general pediatrician, that is not the case. He or she is probably struggling for survival if a major portion of the practice is Medicare.

Give a copy of this editorial to your senior citizen patients and to your Congressman. The public needs to know the truth about what has really happened to the physician payment reform under Medicare. Hopefully, Medicare will eventually be rolled into health care reform and these problems will be corrected by Congress so that the access to medical services for the elderly of this country will be rightfully preserved. ■



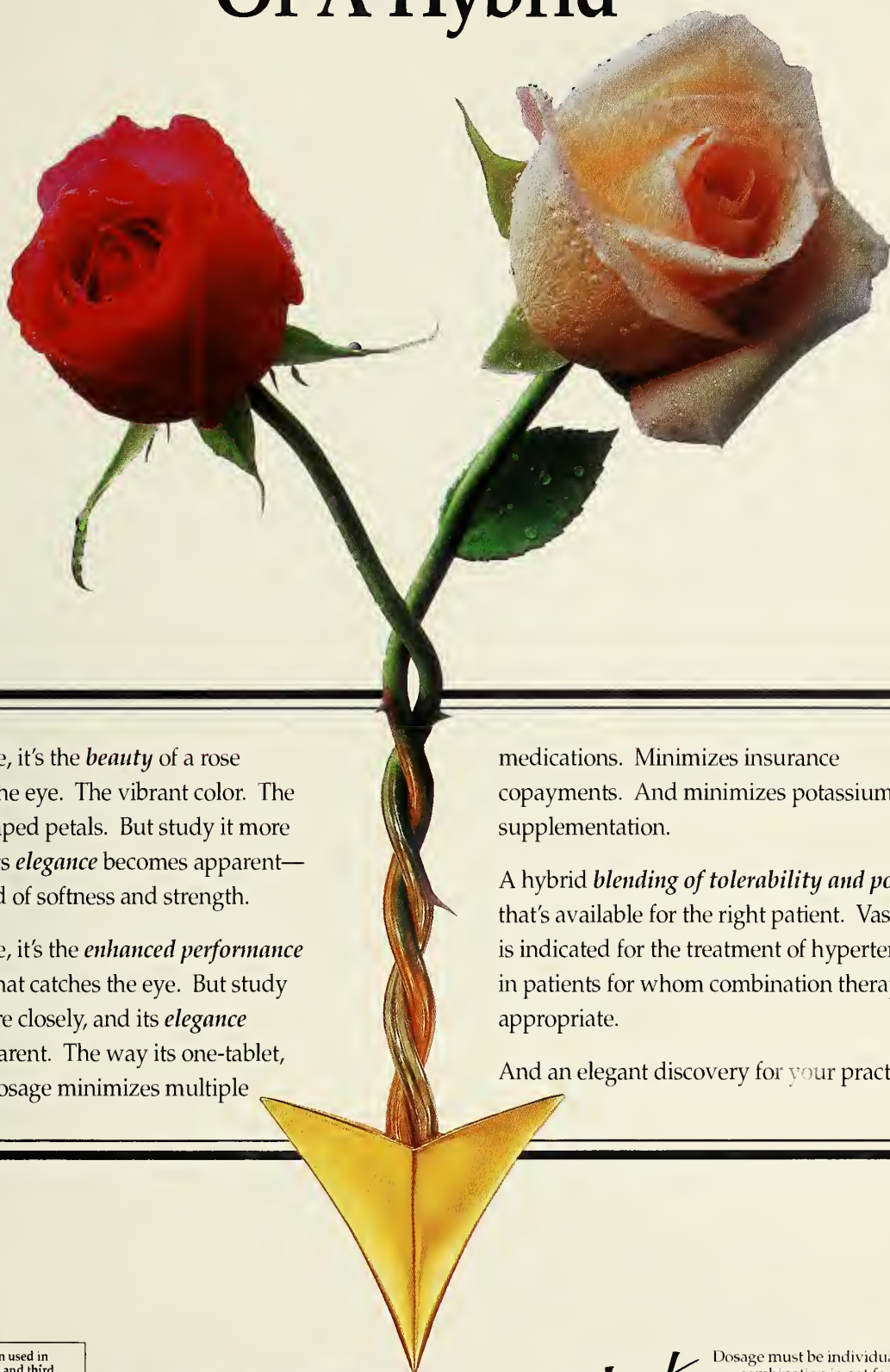
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# Discover The Elegance Of A Hybrid



At first glance, it's the *beauty* of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its *elegance* becomes apparent—a gentle blend of softness and strength.

At first glance, it's the *enhanced performance* of Vaseretic that catches the eye. But study Vaseretic more closely, and its *elegance* becomes apparent. The way its one-tablet, once-a-day dosage minimizes multiple

medications. Minimizes insurance copayments. And minimizes potassium supplementation.

A hybrid *blending of tolerability and power* that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

And an elegant discovery for your practice.

**USE IN PREGNANCY:** When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Vaseretic® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

**VASERETIC® 10-25**  
Enalapril Maleate-Hydrochlorothiazide

*Next*

Dosage must be individualized; the fixed combination is not for initial therapy. Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.



**TABULETS**  
**VASERETIC®**  
(ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)

**USE IN PREGNANCY:** When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC (enalapril maleate-hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

**CONTRAINDICATIONS:** VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

**WARNINGS:** General, Enalapril Maleate, Hypotension: Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, Drug Interactions, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

**Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided. (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

**Neutropenia/Aggranulocytosis:** Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, Drug Interactions, Enalapril Maleate and Hydrochlorothiazide).

**Frequency, Enalapril-Hydrochlorothiazide:** There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 1/2 times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 1/2 times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality, below.)

**Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality:** ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no

10  
mg



25  
mg

alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

**Hydrochlorothiazide, Teratogenic Effects:** Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5.6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

**Nonteratogenic Effects:** These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**PRECAUTIONS:** General, Enalapril Maleate, Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dose reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

**Hemodialysis Patients:** Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

**Hyperkalemia:** Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See Drug Interactions.)

**Cough:** Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

**Surgery/Anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

**Hydrochlorothiazide:** Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hyperkalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hyperkalemia. Hyperkalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see Drug Interactions, Agents Increasing Serum Potassium).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the

treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperurcemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hypoglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathetic patient.

Progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium, this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

**Information for Patients:** Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of the face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

**Hypotension:** Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

**Hyperkalemia:** Patients should be told not to use salt substitutes containing potassium without consulting their physician.

**Neutropenia:** Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

**Pregnancy:** Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

**NOTE:** As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

**Drug Interactions:** Enalapril Maleate, Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

**Agents Causing Renin Release:** The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

**Other Cardiovascular Agents:** Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

**Agents Increasing Serum Potassium:** Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

**Lithium:** Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium. Hydrochlorothiazide: When administered concurrently the following drugs may interact with thiazide diuretics.

**Alcohol, barbiturates, or narcotics**—potentiation of orthostatic hypotension may occur.

**Antidiabetic drugs** (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

**Other antihypertensive drugs**—additive effect or potentiation.

**Cholestyramine and colestipol resins**—Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively.

**Corticosteroids, ACTH**—intensified electrolyte depletion, particularly hypokalemia.

**Pressor amines** (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

**Skeletal muscle relaxants, nondepolarizing** (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

**Lithium**—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations in patients receiving VASERETIC.

**Non-steroidal Anti-inflammatory Drugs**—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vitro* mouse

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bone marrow assay.

**Enalapril Maleate:** There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: re-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenetic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

**Hydrochlorothiazide:** Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

**Pregnancy:** Pregnancy Categories C (first trimester) and D (second and third trimesters). See WARNINGS, **Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.**

**Nursing Mothers:** Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:** VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body As A Whole:* Syncope, chest pain, abdominal pain; *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric:* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash; *Other:* Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

**Angioedema:** Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

**Hypotension:** In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

**Cough:** See PRECAUTIONS, **Cough.**

**Clinical Laboratory Test Findings; Serum Electrolytes:** See PRECAUTIONS.

**Creatinine, Blood Urea Nitrogen:** In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

**Serum Uric Acid, Glucose, Magnesium, and Calcium:** See PRECAUTIONS.

**Hemoglobin and Hematocrit:** Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

**Liver Function Tests:** Rarely, elevations of liver enzymes and/or serum bilirubin have occurred. Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

**Enalapril Maleate:** Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole:* Anaphylactoid reactions (see PRECAUTIONS, **Hemodialysis Patients**); *Cardiovascular:* Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, **Hypotension**); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression. Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported; a causal relationship to enalapril has not been established. *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pemphigus, alopecia, flushing, photosensitivity; *Special Senses:* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, hearing.

**Miscellaneous:** A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia/myositis, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

**Fetal/Neonatal Morbidity and Mortality:** See WARNINGS, **Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.**

**Hydrochlorothiazide—Body as a Whole:** Weakness; *Digestive:* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity:* Purpura, photosensitivity, urticaria, necrotizing angitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia, *Special Senses:* Transient blurred vision, xanthopsia.

\* Based on patient weight of 50 kg.

For more detailed information, consult your DuPont Pharma Representative or see Prescribing Information.

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# Diagnosis, Care and Management of the Pediatric HIV/AIDS Patient in Arkansas

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The first cases of acquired immunodeficiency syndrome (AIDS) in children were recognized in 1982. By 1989, 1736 cases of pediatric AIDS had been reported to The Centers of Disease Control and Prevention. Eighty percent of those 1736 cases are attributed to perinatal or vertical transmission of the human immunodeficiency virus (HIV) by the mother to her newborn. The increase in the number of children infected with HIV by perinatal transmission has been greater than in other transmission categories.<sup>1</sup> As the number of pediatric patients infected with HIV continues to rise, Arkansas Children's Hospital has become a referral center for these patients. The Arkansas Department of Health has recognized the Infectious Disease Clinic at Arkansas Children's Hospital as the Pediatric HIV/AIDS referral center for the State of Arkansas. The majority of infants are being referred from rural areas, after evaluation by their private community physicians.

## TRANSMISSION

Virtually 100% of infants born to HIV positive mothers will have positive serological tests for HIV at birth. Conventional HIV antibody tests do not distinguish between maternal antibody and HIV antibody produced by the infant.<sup>2</sup> A positive HIV test in a newborn, therefore, only means the mother is infected. Vertical transmission from HIV infected mothers is the primary route by which infants become infected. Transmission rates from mother to infant of HIV are reported as being between 20% and 40%, which means that approximately one third of all infants born to infected mothers will actually be infected with HIV. Uninfected children will lose the maternal antibody between 7 and 19 months of age.<sup>3</sup> Due to the persistence of maternal

antibodies and the period of latent infection with HIV, diagnosis of infants in the first 12 months of life is difficult. Prolonged follow-up is therefore essential to determine which infants are infected.<sup>4</sup> Infants may also become infected via breastmilk; therefore, it is recommended, in the United States, that HIV infected mothers should not breastfeed their infants.<sup>5</sup>

Since routine HIV testing is not done on all pregnant females, clinicians should focus attention for HIV testing on those females at risk for infection. These include women who are IV drug users, prostitutes, women with other sexually transmitted diseases, sexually promiscuous with multiple partners, and those women whose sexual partners are at risk for HIV disease. The most significant increases in both HIV infection and AIDS cases are being seen in persons in these categories.

## PRESENTATIONS

The common presenting complaints of children infected with HIV are failure to thrive, recurrent bacterial infections, persistent fever and/or diarrhea, lymphadenopathy, hepatosplenomegaly, and lymphoid interstitial pneumonitis. A large number of infected infants develop significant neurologic abnormalities, manifested as developmental delay or loss of developmental milestones.<sup>6</sup>

Other clinical manifestations of HIV illnesses in children resemble common childhood diseases. A major consequence of HIV infection in children is the markedly increased rate of serious, recurrent bacterial infections.<sup>7</sup> In evaluation of high risk infants in which a firm diagnosis has not been established, the frequency of diaper dermatitis, oral thrush, diarrheal episodes and otitis media should be noted.

Studies state that the average time of onset of AIDS defining illnesses in children who have perinatally acquired HIV infection is 5 to 10 months of age, with approximately 75% becoming ill and dying before their first birthday.<sup>8</sup> More older children are now recognized

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to have been infected with HIV at birth and are surviving beyond previous expectations. Therefore, HIV should not be excluded as a possible diagnosis just because the child is over one year of age.

EVALUATION

Testing for HIV antibody is routinely done by enzyme linked immunoassay (EIA), confirmed by a specific immunoblot, referred to as the Western Blot. Other methods include HIV culture, polymerase chain reaction, and p24 antigen detection. HIV culture is a sensitive method to detect HIV presence, but is expensive, technically difficult, time consuming, and not a standard testing method.<sup>6</sup> Polymerase chain reaction (PCR) for detection of HIV-DNA has become more widely available for the diagnosis of HIV. PCR detects the presence of virus by gene amplification, rather than testing for antibody to the virus.<sup>2</sup> The test, however, is still quite expensive and not routinely available. Tests directed against the p24 antigen of the virus are also used. The detection of antigen is more specific for infection than detection of antibody to the antigen.<sup>3</sup> This test has not been found to be helpful for children less than 6 months of age. Antigen levels are also utilized as a measure of response to antiviral therapy in adults.

Immunoglobulin levels are simple, indirect markers of HIV infection and may correlate somewhat to the degree of clinical symptomatology.<sup>1</sup> HIV infected children usually have extremely elevated IgG levels, but have an abnormal response to antigen stimulation.<sup>7</sup> Tests that measure immunologic parameters can be most helpful in diagnosing HIV infection. T helper lymphocyte counts (CD4), T suppressor counts (CD8), and the CD4/CD8 ratio are baseline T cell function studies. Normal CD4 counts in infants are considerably higher as compared to normal adult CD4 counts.<sup>2</sup> As HIV disease progresses, the number of CD4 lymphocytes in infants, as well as adults, decreases.

Complete blood count (CBC), hepatitis B surface antigen and antibody and syphilis serology are part of the routine baseline laboratory determinations in evaluation of the HIV patient. Any infant born to an HIV infected mother should have HIV testing done at birth and at 3 month intervals.<sup>7</sup> Repeat clinical evaluation and HIV testing are the primary means used to determine which infants are infected with HIV.<sup>2</sup>

THERAPY

Zidovudine (formerly AZT, now referred to as ZDV) therapy is recommended for symptomatic HIV infected children (CDC class P-2). The most common side effects seen with ZDV therapy are neutropenia and thrombocytopenia, which can usually be corrected with dose adjustments.

Didanosine (ddI) is available for children as an antiretroviral agent and utilized for children either not tolerating or immunologically not responding to ZDV therapy. Pancreatitis is a reported side effect of ddI therapy and usually minimized with dose adjustment. Zalcitabine (ddC) is an antiretroviral agent available for use in combination with ZDV. This medication has peripheral neuropathy as a reported adverse effect.<sup>9</sup> The use of either dual therapy or alternating therapies may be utilized for children in later stage of illness, in situations where ZDV resistance is suspected, or in those children whose T cell function is not responding to monotherapy. However, to date, there are no current published studies that support dual therapy in pediatrics.

Due to the high mortality from *Pneumocystis carinii* pneumonia (PCP), prevention is a priority. Trimethoprim/sulfamethoxazole (Bactrim) has been demonstrated to be effective, safe, and well tolerated in children. Dapsone is the alternative for children who do not tolerate trimethoprim/sulfamethoxazole. Pentamidine, either aerosolized or parenteral, is utilized as an alternative regimen in the adult HIV population for pneumocystis prophylaxis. Its use is limited in the pediatric patient due to its routes of delivery. Decisions on when to start PCP prophylaxis is based on pediatric CD4 counts, as recommended by the Centers of Disease Control and Prevention (Table 1).<sup>10</sup>

Intravenous immune globulin therapy (IVIG) given as an IV infusion every four weeks has shown to be beneficial in increasing the length of time between serious bacterial infections. Although the baseline serum IgG level is abnormally high, the functional capability of the infused IgG has been shown to provide circulating protection in those patients whose CD4 counts are not critically lowered.<sup>8</sup> Currently monthly intravenous gammaglobulin infusions are given if children are demonstrated to suffer from recurrent serious bacterial infections and/or not make functional antibody.

Table 1  
CDC Recommended CD4 Levels  
for Pneumocystis Prophylaxis<sup>10</sup>

Age	Start PCP Prophylaxis If:
1-11 Months	CD <sub>4</sub> count less than 1500
12-23 Months	CD <sub>4</sub> count less than 750
24 Months-5 Years	CD <sub>4</sub> count less than 500
≥ 6 Years	CD <sub>4</sub> count less than 200

\*Prophylaxis indicated for CD<sub>4</sub> counts less than 20% of the total lymphocyte count.  
Recommended Regimen: Trimethoprim/Sulfamethoxazole (TMP-SMX) 150 mg TMP/m<sup>2</sup> with 750 mg SMX/m<sup>2</sup>/day orally in divided doses twice daily three times weekly.

Immunizations are to be given at the same schedule as any child. Diphtheria-Pertussis-Tetanus and *Haemophilus influenzae* type B conjugate vaccines should be given at 2, 4, and 6 months of age. The inactivated polio vaccine (IPV) is used instead of the live attenuated oral polio vaccine (OPV) at the same 2, 4, and 6 month schedule. Hepatitis B vaccinations should routinely be started either with the first dose at birth or at 2 months of age, the second given one month after the first and the last of the series given at 6 months after the start of the series. The measles, mumps and rubella (MMR) vaccine is recommended at the 15 month visit, even though it is a live attenuated virus. The 23-valent pneumococcal vaccine is to be given at 24 months of age. It is recommended that these high risk children receive yearly influenza vaccinations.

## SOCIAL ISSUES

Pediatric HIV/AIDS cases are socially complicated. Due to the inability or lack of desire, by infected parents, to provide care and nurturing, abandonment or foster care placement is what some children face. Parental death also places the HIV infected child in a placement situation, as most high risk families do not plan ahead for such problematic issues.<sup>6</sup> Foster care placement is not easily accomplished due to the limited number of foster homes either willing or approved to care for special needs children. The psychosocial assessment must focus on the caretaker roles for the infected child, as well as the infected parent. The financial systems available to each family and support systems appropriate for a family are issues well reviewed by social work. An array of medical and social problems, including drug abuse, lack of family support, refusal of other support systems, and confidentiality issues are commonly exposed.

## PROGNOSIS

HIV disease is now considered a chronic illness of childhood. The prognosis of the HIV infected child is statistically based on viral load, primary care, early diagnosis, and institution of appropriate therapy. There are many children infected with HIV living much beyond previous expectations.

## ARKANSAS DATA

Between 1988 and 1992, there have been 52 children evaluated at Arkansas Children's Hospital for HIV determination and/or related illnesses (Table 2). Of the children evaluated, 68% are African-American, 29% are Caucasian, 3% are Hispanic. Risk factors for the mother included: intravenous drugs (62%), heterosexual contact (28%), blood product transfusion (5%), undisclosed risk factor (5%).

Of the 52 pediatric patients evaluated, 20 patients (39%) have developed AIDS, with 23 patients (44%) converting to a seronegative status. The remaining 9 patients (17%) have remained HIV positive, without advancement, at this time, to an AIDS diagnosis. There have been reports of children who have lost maternal antibody (converted to seronegative) and seroreverted to a HIV positive status.<sup>2</sup> There have been no such cases in the children seen at Arkansas Children's Hospital. The children who have expired were on the average of 13 months of age. Those children continuing to live with an AIDS diagnosis range between 20 months to 10 years of age, with the majority being less than 3 years old. The HIV exposed patient seen at Arkansas Children's is evaluated by a multidisciplinary team which includes the physician, nurse, social worker, nutritional and financial counselors, and the caretakers are given HIV/AIDS educational materials.

## THE FUTURE

Services must be provided to families, since the infected infant is only a portion of the problematic scope of infection with the human immunodeficiency virus. Case management should focus on family issues and involve care for the infant as well as siblings and parents. Routine care should be delivered by the primary care physician in collaboration with a center having expertise in providing specialized immunologic testing and antiretroviral therapies. The comprehensive medical and supportive care needed can be provided by the joint efforts of the local physician and the pediatric HIV team.

The Infectious Disease Clinic at Arkansas Children's Hospital currently meets weekly. Referrals and appointments for the clinic can be made through the Infectious Disease office by calling (501) 320-1416.

Table 2  
Serological Status of HIV Infected Children

Year	Patients Evaluted	Documented AIDS	Sero Converted	Remain HIV+ Not AIDS	Lost to Follow-up	Expired
1988	8	4	3	-	1	4
1989	9	3	5	-	1	1
1990	4	3	1	-	-	-
1991	18	5	10	-	3	1
1992	13	5	4	4	-	1



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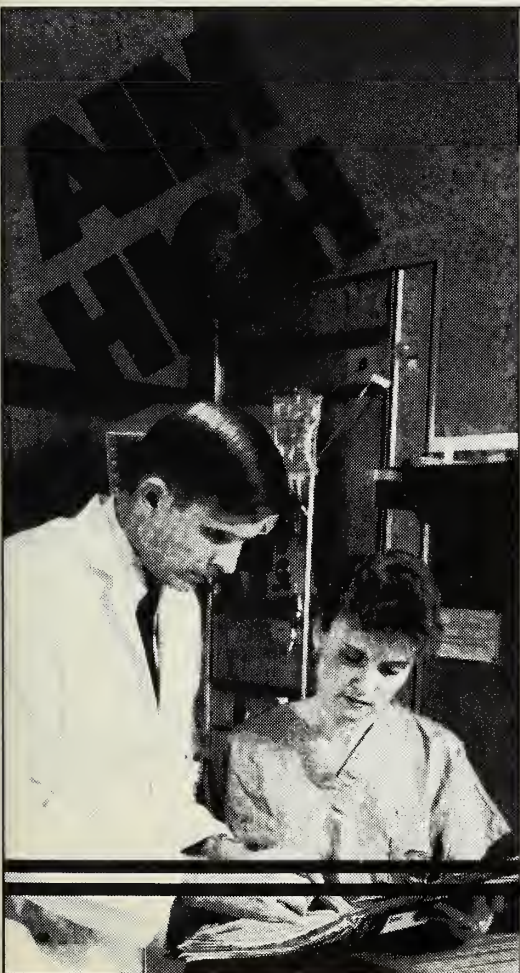
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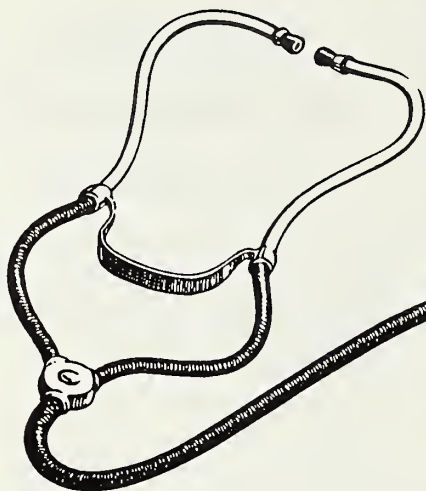
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# Overdoses of Nuclear Medicine Cause Concern for Hospitals, Physicians, Patients - And for the Nuclear Regulatory Commission

Kathleen M. Roman\*

The Nuclear Regulatory Commission (NRC) is charged with responsibility for protecting Americans from health threats caused by exposure to radioactive materials. Included in that mandate is monitoring of misadministrations of radioactive materials used in both diagnostic and therapeutic treatments.

Recently, the threat of real or potential injury to patients receiving nuclear medicine has been increasingly scrutinized by the media.

One midwest hospital acknowledged that at least 500 patients had received overdoses of nuclear medicine within the last four years. Overdose dose estimates ranged from twenty to forty percent above the actual prescriptions.

According to NRC records, diagnostic errors in providing radiation therapy can include: mistakes in orders written for nuclear medicine scans; the preparation of radiopharmaceuticals; and in the administration of radiopharmaceuticals. Therapy misadministrations can include: error in dose calculation; error in identifying treatment; insufficiently trained personnel; error in identifying strength of implanted brachytherapy sources; error in verifying placement of brachytherapy sources in relation to treatment site; and inadequate patient restraint.

The NRC says that about 7 million diagnostic procedures are performed annually in the United States. This figure includes: 30,000 radiopharmaceutical therapy procedures (the ingestion or injection of radioactive compounds for patient therapy treatment); and 50,000 brachytherapy procedures (the insertion or implantation of sealed sources containing radioactive material for patient therapy treatment); as well as about 100,000 patients who receive Co-60 teletherapy treatments (external use of radiation for patient treatment) each year.†

The 1991 *Analysis and Evaluation of Operational Data*, published by the U. S. Nuclear Regulatory Commission, states that "the (reported) number of NRC diagnostic misadministrations in 1991 is about the same as in 1990 and about 10 percent higher than the average number received over the previous 9 years. The number of therapy events reported during 1991 was about two times the average number reported in the previous 10 years." While the NRC indicates that these rates "remained low" is also clear that many incidents are not reported to the NRC and, in some instances, hospitals have acknowledged record tampering by employees fearing discipline.

In a "tragedy-of-errors," three physicians failed to engage in the necessary amount of communication and record surveillance crucial to the treatment of cancer patients. With deadly results.

The plaintiff was a fifty-year-old male suffering from colorectal cancer. A pathological report following a tissue resection revealed adenocarcinoma of the colon with 11 of 21 lymph nodes positive for cancer. An MR scan performed before discharge indicated multiple liver metastases, but ensuing results of the frozen section studies were negative.

The patient was a wealthy gentleman who owned several businesses, who had many work-related obligations and his greatest concern at the time of discussion of his chemotherapy was that he needed to be as free as possible to resolve some of his business affairs.

The first defendant, Dr. Green, was a 38-year-old non-board-certified oncologist. It was he who referred the patient for the resection. Dr. Green discussed various treatment protocols with the patient but the patient did not want to be hospitalized because of his work commitments. It was therefore decided that the patient would arrange for home nursing care and intravenous fluids.

Dr Green was preparing to leave for vacation during this time and he turned administration of the ther-

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apy over to his partner, Dr. Brown, a 38-year-old non-board-certified oncologist. There is controversy in the testimony of these two physicians for each alleges that it was the other who designed the patient's treatment plan. In fact, there was no discussion or agreement between these two regarding the planned protocol for this patient. It just "happened."

Dr. Green went on vacation during this time; he left neither phone number nor address where he could be reached. And expert witnesses were critical of his involvement in the case for three reasons: 1) Dr. Green did not clearly establish to his patient the severity of his illness, allowing treatment plans to waffle about; 2) Dr. Green left for vacation without having established a treatment protocol that both the patient and Dr. Brown knew of and had agreed upon; 3) Dr. Green did not leave any information regarding his whereabouts during his vacation.

Each of these two physicians maintained that it was the other who developed the treatment protocol. But Dr. Green did acknowledge that the patient had probably received a dose of 5-FU in excess of proper administration of 5-FU by IV push, whereas it became clear that Dr. Brown really didn't know what doses might be considered high or low.

Chemotherapy nurses testified that twice they made phone calls to Dr. Brown's office to clarify the written orders. Both nurses testified that they thought 5-FU administered by IV "push push" was high.

Interestingly, when a suit was filed, Dr. Brown's original notes regarding this case indicate that she had been "only peripherally involved in the care of this patient. I saw him while covering for my partner." Dr. Brown wrote that she had only seen the patient three times when she checked on his "chemotherapy administration." Dr. Brown was criticized by expert witnesses for failing to have a clear-cut understanding regarding the treatment protocol as well as for failing to appropriately order, monitor, and assure care for the patient's needs.

The plaintiff did not do well at home and was finally admitted to the hospital via ambulance in an extremely hypotensive and dehydrated state. He was started on fluids and taken to Intensive Care where orders for antibiotics were later written.

IC nursing staff testified that the plaintiff had a "burned" appearance. When questioned regarding this description the nurses testified that the plaintiff appeared "cooked from the inside." However, Dr. White, the third partner, a 46-year-old non-board-certified oncologist was on duty when he was requested to check the plaintiff and simply indicated that the patient was suffering from a skin rash, "possibly the result to an allergy to one of the medications." Dr. White admitted that he did not review the patient's

chart to see what medications had been prescribed. Dr. White acknowledged that the particular dose of 5 FU was 25 percent to 30 percent higher than he was familiar with under other protocols. Yes he might have questioned the dosage had he looked at the chart, he said.

Sixty hours after being admitted to the hospital, the patient died of sepsis related to neutropenia. "My feeling," wrote an eminently-qualified witness who reviewed the case, "is the route he received for chemotherapy as well as the doses of the chemotherapy he received directly caused his neutropenia, his sepsis and his shock as this particular chemotherapy/immunotherapy regiment is fraught with significant hematologic toxicities."

The distraught family ultimately sued, not because family members believed that the plaintiff should have been cured but because he had agreed to undergo chemotherapy believing that the treatment might give him needed time to get his business affairs completely in order. Instead, the family alleged, the treatment did exactly the opposite. It stole what little time the plaintiff had and left the family deprived of its loved one and at a financial disadvantage.

*Note: Interestingly, a letter-to-the-editor, appearing in the January 14, 1993 issue of The New England Journal of Medicine, contained chemotherapy frequency information which a sharp-eyed reader (Vol. 328, No. 21) noted and pointed out. At issue was intravenous doses of cisplatin and dacarbazine given intravenously either "every three to four weeks" or "three to four times weekly."*

† Names used in this article are purely fictitious.

U.S. Nuclear Regulatory Commission, "10 CFR Part 35, Basic Quality Assurance Program, Records and Reports of Misadministrations or Events Relating to the Medical Use of Byproduct Material," *Federal Register*, Vol. 55, No. 10, January 16, 1990, pp. 1439-1449.







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# An Exercise Therapy Program for Balance Disorders

John Dickens, M.D.\*  
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## ABSTRACT

Patients with chronic balance or disequilibrium disorders can be difficult to evaluate and treat, due to the complex integration of sensory systems which control balance function. There is a trend away from placing these patients on long-term sedative medication. In fact, long-term sedative medications may actually reduce or prevent central compensation. For patients with chronic balance disorders who have already been appropriately treated with medicine and/or surgery, we now strongly recommend an active exercise therapy program, which promotes central compensation and improves general fitness.

The number of people in the United States who see a physician each year for symptoms of disequilibrium or vertigo continues to rise; a survey by the Ambulatory Medical Care Association recently showed approximately 7,000,000 visits for symptoms of balance disorders.<sup>1</sup> One in three Americans will experience some episode of dizziness by age 65. Certainly, with the aging of the population, the number of physician visits for symptoms of disequilibrium will continue to increase. Fortunately, for the majority of patients with acute disorders, the only medical treatment necessary is temporary symptomatic control. For reasons that are still poorly understood, however, some of these patients develop chronic balance system problems and may even develop inappropriate compensatory behaviors. Patients with chronic disorders of balance and disequilibrium can be quite problematic for physicians attempting to treat the complex balance system, which involves multiple sensory input including vision, proprioception and vestibular pathways with coordinated automatic muscle output.

Patients with chronic balance disorders who are employed often become so handicapped by their symptoms that their work is affected; similarly, such chronic symptoms affect the quality of patients' personal and social lives. Recently, there has been a trend away from sedating these patients to control their symptoms; on the contrary, there is a strong trend nationally toward placing these patients in active exercise therapy programs to habituate their responses and then to hasten and strengthen central nervous system compensation.<sup>2</sup>

The idea of exercises for vestibular rehabilitation is not new. In 1941, Hawthorne and Cooksey introduced such exercises for labyrinthine disorders.<sup>3</sup> In most instances, these exercises have been ineffective in that their range of potential application is limited; patient compliance is often poor. These exercises are primarily head and neck exercises with the intent of provoking and habituating vertiginous responses caused by benign positional vertigo (BPV) or benign paroxysmal positional nystagmus (BPPN). Obviously, these exercises have a limited application and effectiveness.

## DIAGNOSIS AND PATIENT SELECTION

In the last few years, a new technology for the assessment of balance has become available clinically. Known as computerized dynamic posturography (CDP), this instrumentation is a vital aid in diagnosing balance disorders, as it isolates and quantifies not only vestibular input but also contributions from the visual and proprioceptive senses involved in balance orientation.<sup>4</sup> CDP presents the first objective means for quantifying overall balance function while at the same time providing some separate analysis of individual sensory systems. The patient's balance function can be compared with an age related normative base. In addition to assisting with diagnosis, CDP has highlighted certain maladaptive behavior developed by patients as inappropriate compensatory mechanisms for managing balance problems. When combined with the informa-

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tion obtained about the vestibular system from the new forms of computerized electronystagmography, CDP fosters a more functional diagnosis and treatment plan.

Many dizzy patients arrive having previously been evaluated by a number of specialists. Their use of various anti-vertiginous medications may be of little or negative benefit in controlling chronic problems. Sedative medications used over the long term can actually reduce or prevent central compensation. For patients who have been well diagnosed and appropriately treated with medicine and surgery, and who continue to have chronic balance disorders, we now strongly recommend an active exercise therapy program. Table I lists the types of diagnoses which may benefit from such a program.

EVALUATION

For each patient entering the program, an evaluation visit is conducted in which the patient's skills in balance and motor function are assessed. Since an appropriate rehabilitation program addresses not just vertigo habituation and balance retraining, but all the patient's sensory motor problems, a comprehensive evaluation includes an overall assessment of the neuromusculoskeletal system. Measures of physical status include traditional assessment of range of motion, strength, pain sensation and coordination. Vertigo assessment provides insight into the characteristics of the patient's dizziness and determines the positions or movements that provoke symptoms of dizziness. The Vertiginous Positions Test examines the intensity and duration of vertigo in response to a series of 18 positions and movements, including Hallpike maneuvers. Other assessments include balance control - sitting, standing and walking - postural movement strategies, motor coordination, gaze stabilization and eye-head coordination. The purpose of this complete assessment is to compile a comprehensive list of sensory motor problems contributing to loss of independent function. Particular emphasis is given to assessment of position and movement related to dizziness and sensory motor components underlying disequilibrium.

THERAPY

Our therapy program consists of exercises in three areas: 1) Head and trunk exercises and walking activities for habituation of dizziness; 2) balance retraining; and 3) a general fitness activity to promote long-term retention of central nervous system compensation. Patients are seen at our clinic for therapy on a weekly or bi-weekly basis; therapy is usually conducted for approximately two to six weeks. During this period, patients are required to perform exercises at home twice daily for 10 to 15 minutes.

It is common for dizziness symptoms to increase temporarily during the first week or two of therapy. The

necessity for compliance and consistency is stressed to each patient in order to achieve long-term results. In those patients who are compliant with our program, successful remediation or reduction of symptoms is possible in 60 to 90 percent.

CONCLUSION

Patients with disorders of disequilibrium benefit from a brief, structured program which promotes identification of functional problems and teaches adaptive behaviors. Taking many patients with chronic disequilibrium off sedative medication actually improves balance and hastens a more complete central compensation. This allows the natural mechanisms of central plasticity to remediate for any aberrations of sensory input.

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3. Cooksey FS. Rehabilitation in Vestibular Injuries. *Proc Royal Soc Med*, 39: 273-275, 1946.  
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TABLE I

APPROPRIATE FOR TREATMENT REFERRAL

Associated diagnoses include:	
Decreased Sensitivity	
Post neuronitis - not in active disease state	
Ototoxicity	
Head trauma	
Vascular occlusions	
Postsurgical patients - acute or chronic	
Asymmetric vestibulopathy	
Disorder Function	
BPPN (benign paroxysmal positional nystagmus)	
BPV (benign positional vertigo)	
Fistula	
Central Problems	
Stroke	
Head trauma	
Cerebellar problems	
Combined Peripheral and Central Problems	



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# Managed Care Information, Definitions and Contract Considerations

Managed care is a generic term that has come into use during the last decade. The definition of "managed care" is not commonly agreed to. There are numerous acronyms used as names of various managed care organizations (MCOs). They include HMOs, PPOs, PPAs, EPOs, DPOs, IPAs, CMPs, POSs, HPOs, DHOs, etc. (see definitions).

The national association of Children's Hospitals defines managed care as:

"an attempt to contain health care costs by controlling how and where patients obtain health care services. Any health insurance or health financing mechanism or financial inducement intended to direct or restrict the patient's choice of provider or the patient/physician's choice of treatment modality".

A recent publication of the American Academy of Family Physicians entitled "Family Physicians and Managed Care" did an excellent job in defining and explaining managed care. They defined managed care as:

"a means of providing health care services within a defined network of health care providers who are given the responsibility to manage and provide quality, cost-effective health care".

Some of the tools used by the managed care organizations to reduce hospital admissions and lengthy stay include:

- o preadmission testing
- o concurrent utilization review
- o discharge planning
- o retrospective utilization review
- o second surgical opinion
- o same day surgery

- o home care
- o case management
- o preadmission certification

Early in this past decade we saw efforts at reducing hospital admissions. They were successful by HMOs and others using the methods mentioned above. We have also seen efforts to control costs outside hospital settings using such techniques as:

- o referral authorizations for subspecialty and other nonprimary care services
- o case management
- o drug formularies
- o use of defined provider networks
- o cost sharing through copayments, coinsurance, and deductibles
- o provider incentive/risk sharing systems

The AAFP publication lists many considerations when contracting with the managed care organizations such as:

- o How many managed care patients do you need and want over the next few years?
- o How many managed care contracts are feasible/necessary to reach your volume of patients in your practice? Each contract has certain stipulations and requirements causing some administrative burdens within your office.
- o Case management/gatekeeper requirements.
- o What is the mix of physicians included in the MCO panel (e.g., number of primary care physicians, number of nonprimary care physicians, and the different numbers of each)?
- o What is the projected mix of MCO enrollees (e.g., age, sex, commercial, Medicare, Medicaid, etc.)?
- o The degree of control of influence by various physician groups (i.e., primary care verses

specialist) and what is the representation on the governing board or committees that has a voice in the MCO's operation.

- o Which hospitals, specialists, and ancillary providers are participating?
- o Type of utilization management and quality management systems involved
- o Billing and administrative requirements
- o Management information and monthly reports especially for those physicians who are at risk for part of their fees.
- o The solvency/viability and general reputation required by the MCO.
- o Exclusivity requirement (e.g., are patients allowed to go only to panel physicians or can they under some circumstances be referred outside the panel)
- o Methods of compensation (fee for service, discounted fee for service/fee schedule).
- o Degree of risk by physicians (fee-for-service with a withhold, primary care capitation, physician and ancillary services capitation)
- o Limits on balanced billing and harmless provisions
- o Coordination of benefits
- o Risk/bonus pools specifics
- o Retroactive additions and deletions of eligible members
- o Employer audits of MCO and provider records
- o Denial of payment conditions
- o Timely billing and claims payment requirements
- o Rate increases
- o Who is responsible for copying costs?
- o Actuarial soundness of premium rates
- o Timeliness of payment
- o Case management reimbursement (If this is a factor.)
- o Physician incentives
- o Copayments, coinsurance, and deductibles
- o Noncovered services (Who pays? Are you allowed to charge?)
- o Limitations for major disasters, epidemics, or labor disputes

Basic Terms and Conditions - Provision of services by physician:

- o List of covered services
- o Standards of care
- o Referrals
- o Hospitalization
- o Nondiscrimination of members in physician's practice
- o Access of patients to physicians
- o Medical records requirements
- o Practice sites
- o Signs required in physician's office
- o Compliance with MCO rules and regulations

- o Exclusivity requirements
- o Coordination of benefits (COB) procedures
- o Release of medical records and confidentiality
- o Mandatory audits by MCO or its agent
- o Indemnification and hold harmless provision
- o Professional liability insurance requirements
- o General liability insurance requirements

Administrative Responsibilities of MCO:

- o Monthly patient/member activity and cost reports to physician
- o Eligibility reporting
- o Payment/payment in full
- o Utilization review and quality assurance
- o Patient transfers out of PCP panel upon request
- o Independent contractor provision
- o Grievance procedures
- o Site evaluations
- o Advertising and marketing
- o Data support
- o Licenses and permits
- o Confidentiality

Other Basic Terms and Conditions:

- o Renegotiation language
- o Mutual indemnification
- o Mutual insurance requirements
- o Conflicts of interest disclosure requirements
- o Term, termination, and default
  - Term of contract
  - Termination provisions (who, when, and how)
  - For cause
  - No fault
  - Notification
  - Extension
  - Removal of participating provider
- o Continuing education requirements
- o Hospital privileges requirements
- o General provisions
  - Waiver:
    - Entire agreement
    - Record maintenance
    - Severability of contract
    - Amendments to contract
    - Governing law
    - Successor and assignments
    - Notices
    - Disputes/Arbitration
- o Confidentiality
  - Mutual responsibility
  - Patient records
  - Utilization data
  - Quality improvement
  - Statutory requirements



# Health Care Reform Terms

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**Accountable Health Plans (AHP)** - Federally sanctioned managed care networks that will compete for patients on the basis of quality. (Part of the Clinton health care reform considerations.)

**Actuarial studies** - actuarial studies normally consist of statistical projections of utilization and costs of specific benefits for a defined population.

**Administrative Loading** - the amount added to the prospective actuarial cost of the health care services (pure premium) for expenses of administration, marketing, and profit.

**Adverse selection** - the enrollment of a disproportionate percentage of persons who are poorer risks - that is, persons who are more ill, more prone to suffer loss, or make claims - than the average person.

**Clinic without walls** - a framework that allows groups of physicians to form a corporate relationship without combining their physical locations.

**Closed-panel system** - a medical organization in which admission of other doctors is limited by the group and in which members can use only doctors in the group for their medical care. A staff-model HMO is a closed-panel system, while a PPO is an open-panel system.

**Community rating** - determining insurance rates without respect to characteristics or utilization of the subject population. Premiums may vary according to benefit packages, but not by health status. Thus, an employed group with characteristics likely to lead to high utilization cannot be charged a higher rate than a group without such characteristics.

**Community rating by class** - a modification of established community rating, whereby individual groups can have different rates depending on the composition by age, sex, marital status, and industry.

**Consumer health alliances** - these are regional cooperatives between government and the public that oversee the new payment system. Once referred to as health insurance purchasing cooperatives (HIPCs), the alliances would make sure health plans within a region conformed to federal coverage and quality standards, and see that they kept costs within any mandated budget. (Part of the Clinton health care reform considerations.)

**Coordination of benefits (COB)** - a typical insurance provision whereby responsibility for payment of medical services is allocated among carriers when a person is covered by more than one employer-sponsored health benefit program. This coordination prevents a person from being reimbursed twice for the same medical service.

**Cost sharing** - responsibility for partial payment by the patient for service rendered. Cost sharing can include 1) coinsurance, which is a patient's responsibility for payment of a specified percent of incurred charges; 2) copayment, which is a patient's responsibility for payment of a specified dollar amount per day or per unit of service; 3) deductible, which is a patient's responsibility for a specified amount of incurred expense before third-party coverage can begin.

**Cost shifting** - the phenomenon of passing along costs not paid by one consumer as higher charges to another consumer.

**Enterprise liability** - a little-known and never tried concept considered by the Clinton Administration that would transfer most malpractice risk from doctors to institutions, hospitals, insurance companies, HMOs or IPAs.

**ERISA** - The Employee Retirement Income Security Act. ERISA exempts self-insured health plans from state regulation and laws such as mandated benefits.

**Exclusive Provider Organization (EPO)** - EPOs are similar to PPOs in their organization and purpose. Unlike PPOs, EPOs limit beneficiaries to participating providers. In other words, beneficiaries covered by an EPO are required to receive all of their covered services from providers that participate in the EPO, similar to an HMO. The EPO does not cover services received from other providers. Some EPOs parallel HMOs in that they not only require exclusive use of the EPO provider network, but also use a "gatekeeper" approach to authorize nonprimary care services.

**Federally Qualified HMOs** - HMOs that meet certain federally stipulated provisions aimed at protecting consumers, e.g., providing a broad range of basic health services, assuring financial solvency, and monitoring the quality of care. HMOs must apply to the federal government for qualification. The process is administered by the Office of Prepaid Health Care of HCFA.

**Global Budgets** - limits on categories of health spending.

**Group or Network HMO** - an HMO that contracts with one or more independent group practices to provide services in one or more locations, in which physicians are prepaid on a capitation basis.

**Group Practice Model** - an HMO model in which the HMO contracts with one or more medical group(s) on a capitation basis for the provision of services. The physicians practice in a common facility and use common staff. Income is pooled and distributed according to an agreed-upon plan.

**Health IRAs** - proposed tax-preferred plans to encourage saving for future medical expenses.

**Health Insurance Purchasing Cooperative (HIPCs)** - these regional consumer groups would shop for the highest-quality plan at the lowest price on behalf of a large number of people, including employees of small businesses. (See consumer health alliance.)

**Hold Harmless** - a clause frequently found in contracts, whereby the parties agree that one party shall not be held liable for the actions of the other party. This language does not preclude a managed care company from being sued if one of its physicians is sued. It may also refer to language that prohibits the provider from billing patients in the event a managed care company becomes insolvent. State and federal regulations may require this language.

**Incentives** - as related to medical care delivery, this term refers to economic incentives for providers to motivate efficiency in patient care management.

**Indemnify** - to make good a loss.

**Individual Practice Association (IPA)** - a MCO such as a HMO which contracts with individual physicians who practice in their own offices and continue to see their regular patients. Unlike other HMOs the IPA usually reimburses the physicians on a fee-for-service basis. This type of system combines prepayment with the traditional means of delivering health care, i.e., physician office/private practice and use of hospitals, nursing homes, and so on.

**Job-lock** - the inability of individuals to change jobs because they would lose crucial health benefits.

**Lock-in** - an expression referring to an attribute of most MCOs whereby the medical care of a member is not covered by the MCO unless it is rendered by participat-

ing physician or physician/institution otherwise authorized by the MCO.

**Managed care** - a relatively new term coined originally to refer to the prepaid health care sector, (e.g., HMOs and PPOs). In general, the term refers to a means of providing health care services within a defined network of health care providers who are given the responsibility to manage and provide quality, cost-effective health care. Increasingly, the term is being used by many analysts to include PPOs and even forms of indemnity insurance coverage that incorporate preadmission certification and other utilization controls.

**Managed Care Organization (MCO)** - A generic term that includes all forms of organizations that provide managed health care services (e.g., HMOs, PPOs, CMPs, EPOs, DPOs, PPAs, etc.).

**Managed competition** - a health insurance system that would band together employers, labor groups, and others into insurance purchasing groups. Employers and other collective purchasers would make a set contribution toward purchase of insurance for individuals they represent. The set contribution acts as an incentive for insurers and providers to compete and hold down costs.

**Managed cooperation** - although the Clinton Task Force no longer uses the phrase "managed competition" to describe its model for health reform, it has yet to come up with what it considers a satisfactory alternative. For now, some officials are using "managed cooperation" to describe the system in which providers would join federally approved managed-care networks.

**Market share** - that part of the market potential that a managed care company has captured; usually market share is expressed as a percentage of the market potential.

**Medical Services Organization (MSO)** - membership organizations that provide services to its members such as: 1) assistance in forming groups; 2) contract review and advice; 3) contract negotiations for groups; and 4) group purchasing, etc.

**Network model** - an organizational form in which the MCO contracts for medical services within a "network" of medical groups.

**Open enrollment** - the time span during which persons in a dual choice health benefits program can select one of the health plans being offered. Also the period referred to in Section 110.107 of the federal qualification



regulations during which a federally qualified HMO must make its coverage available without restrictions to individual (nongroup) subscribers who wish to enroll.

**Open-panel MCO** - an MCO in which any licensed physician in an area is eligible to join the MCO. An IPA is an example of an open-panel plan.

**Outside referral** - referral to a provider not on the MCO's staff, or not within the group contracting to deliver medical services.

**Per capita health care spending** - annual spending on health care per person. Per capita spending in 1992 was estimated at \$3,057.

**Play or pay** - employers would be required to provide health insurance to their employees or to pay a special government program tax.

**Point-of-service plan** - the latest fashion in managed care, but differs from regular MCOs in one critical aspect - patients who decide to go outside the plan pay more out-of-pocket.

**Portability** - an individual changing jobs would be guaranteed coverage with the new employer without a waiting period or having to meet additional deductible requirements.

**Practice parameters** - strategies for patient management developed to assist physicians in clinical decision-making. Parameters improve quality and assure appropriate utilization of health services.

**Preferred Provider Arrangement (PPA)** - an arrangement whereby a third-party payer contracts with a group of medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

**Preferred Provider Organization (PPO)** - PPOs are entities through which employer health benefit plans and health insurance carriers contract to purchase health care services from a selected group of participating providers. Typically, participating providers in PPOs agree to abide by utilization management and other procedures implemented by the PPO, and agree to accept the PPO's reimbursement structure and payment levels. The employer health benefit plans and/or insurance carrier then establish financial incentives in the form of increased benefits for their employees to use the participating preferred hospitals and physicians. In contrast to typical HMO coverage, PPO coverage permits members to use non-PPO providers, although higher levels of coinsurance or deductibles routinely

apply to services provided by these nonparticipating providers. Some PPOs are now emerging that require providers to share in the financial risk, and others are employing the gatekeeper concept.

**Reinsurance** - insurance purchased by MCOs and insurance companies to limit their financial exposure to certain dollar amounts, above which the reinsurer assumes the risk. Typical reinsurance risk coverage are 1) individual stop-loss; 2) aggregate stop-loss; 3) out-of-area; and 4) insolvency protection. As managed care companies grow in membership, they usually reduce their reinsurance coverage (and related direct costs), being in a financial position to assume such risks themselves.

**Rider** - a legal document which modifies a health care service contract or insurance policy, usually decreasing the coverage to be provided.

**Risk pool** - a pool of money that is at risk for being used for defined expenses. Commonly, if the pool of money that is put at risk is not expended by the end of the year, some or all of it is returned to those managing the risk.

**Self insurance** - the practice of an employer or organization assuming complete or partial responsibility for health care losses of its employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative services contract with an independent organization (TPA).

**State Mandated Benefits Laws** - state laws requiring insurance contracts to provide coverage for certain health services (e.g., in vitro fertilization) or for services provided by certain health care providers (e.g., audiologists). Self-insureds are exempt from these requirements. There are over 800 mandates nationwide.

**Stop-loss** - an arrangement between a managed care company and a reinsurer whereby absorption of pre-paid patient expenses are limited, either in terms of overall expenditures and deficit, or by limiting losses on an individual expensive hospital and/or professional services claim.

**Third-Party Administrator (TPA)** - provides services to employers or insurance companies for utilization review, claims processing, and benefit design.

**Underwriting** - the process of selecting, classifying, evaluating, and assuming risks according to their insurability.

# Outdoor MO

Information provided by  
the Arkansas Game & Fish Commission

## SHOOTING RANGE OFFERS CONVENIENT FACILITY TO SHARPEN SKILLS

A shortcoming of many Arkansans is going out to hunt without shooting practice. They depend on hitting a target from past experiences, and they rely on the sights and other functions of their firearms to be unchanged from last year.

A little time on a shooting range can solve these problems. A convenient facility in Central Arkansas is the Arkansas Game and Fish Commission range at Camp Robinson Wildlife Demonstration Area east of Mayflower.

The newly-renovated range is open from 9 a.m. to 5 p.m. Wednesdays through Saturdays. There is a rifle range with covered shooting benches and target holders at several distances. Another range is for handguns. A trapshooting facility and a skeet range provide shotgunners practice opportunities.

## SPORTING CLAYS RANGES OFFER REALISTIC PRACTICE FOR SHOTGUNNERS

Arkansans who go afield with shotguns for dove hunting, quail hunting, duck hunting and other endeavors are usually enthusiastic about sporting clays outings - after they get over the frustrations.

The clay target game, developed in Great Britain and modified in this country, is built around a series of stations that resemble hunt conditions. It is both exciting and challenging. Wingshooters tend to like it for pre-hunt or off-season practice and for the unique competitive qualities it provides.

Frustrations? Yes. These are prevalent for first-timers on a sporting clays range.

A major difference in sporting clays shooting from the traditional skeet or trap is that each station of sporting clays presents targets tossed at different angles and heights and with the shooter working from varying positions.

Scores are lower than those for skeet and trap for most shooters, and an experienced shotgun user averages breaking only about a third of his or her targets on a first try at sporting clays. Improvement generally follows, though.

Arkansas has several privately owned sporting clays ranges open to the public for shooting. A phone call is suggested to learn hours of operation, costs and other details.

Sporting clays ranges in the state include:

- Cordell Game Birds Range, Malvern, 332-3215.
- Crowley Ridge Shooting Resort, Forrest City, 633-3352.
- Grandview Plantation Club, Columbus, 983-2526.
- L'Anguille River Hunt Club, Forrest City, 633-3352.
- Mid America Sporting Clays, Forrest City, 633-3352.
- Nevada County Game Birds, Buckner, 899-2902.
- Sand Creek Sporting Clays, Lockesburg, 289-2284, 289-3375.
- Sanders Lagrue Hunt Club, Stuttgart, 673-2796.
- Sugar Creek Sporting Clays, Bentonville, 273-0848.
- Thunder Valley Sporting Clays, Batesville, 793-6350.
- Wild Wings Sporting Clays, Batesville, 793-6350.

## PORTION OF DEER ZONE BOUNDARY ERRONEOUS IN REGULATIONS BOOKLET

A small portion of the boundary between Deer Zones One and Two is in error in the current Hunting Regulations pamphlets of the Arkansas Game and Fish Commission. The affected area is in Carroll and Boone counties.

The official boundary description for Zone One is: start at the northwest corner of Arkansas, go south on the Arkansas-Oklahoma state line to Interstate 40, east to state Highway 23, north to state Highway 16, east to state Highway 21, north to state Highway 43, north to state Highway 103, north to U.S. Highway 412 (formerly state Highway 68), north to U.S. Highway 62, east to Long Creek east of Alpena, north on Long Creek to Table Rock Lake, north along the eastern edge of Table Rock Lake to the Arkansas-Missouri stateline, then west on the state line to the northwest corner of Arkansas.

## A Look Outdoors

**THRU DECEMBER 24:** Sixty-five Arkansas radio stations will be airing messages about fall hunting and other outdoors activities.

The messages are a project of the Arkansas Game and Fish Commission, Wal-Mart Stores and the Arkansas Radio Network (ARN). Messages include season forecasts, hunting dates and safety tips and will run Mondays and Thursdays at 6:55 a.m. and 4:55 p.m.





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FAX: 214-484-4395

## TAKE THE FIRST STEP TO RECOVERY

The Arkansas Medical Society Physicians' Health Committee is interested in the well being of Arkansas physicians. Through effective intervention, treatment referral and monitoring of health conditions, the Physicians' Health Committee's services enable physicians to continue to deliver safe and effective patient care.

The Committee is composed primarily of physicians who "have been there" and want to help their colleagues from making a mistake.

## ON CALL FOR YOU

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## VACATION HOMES

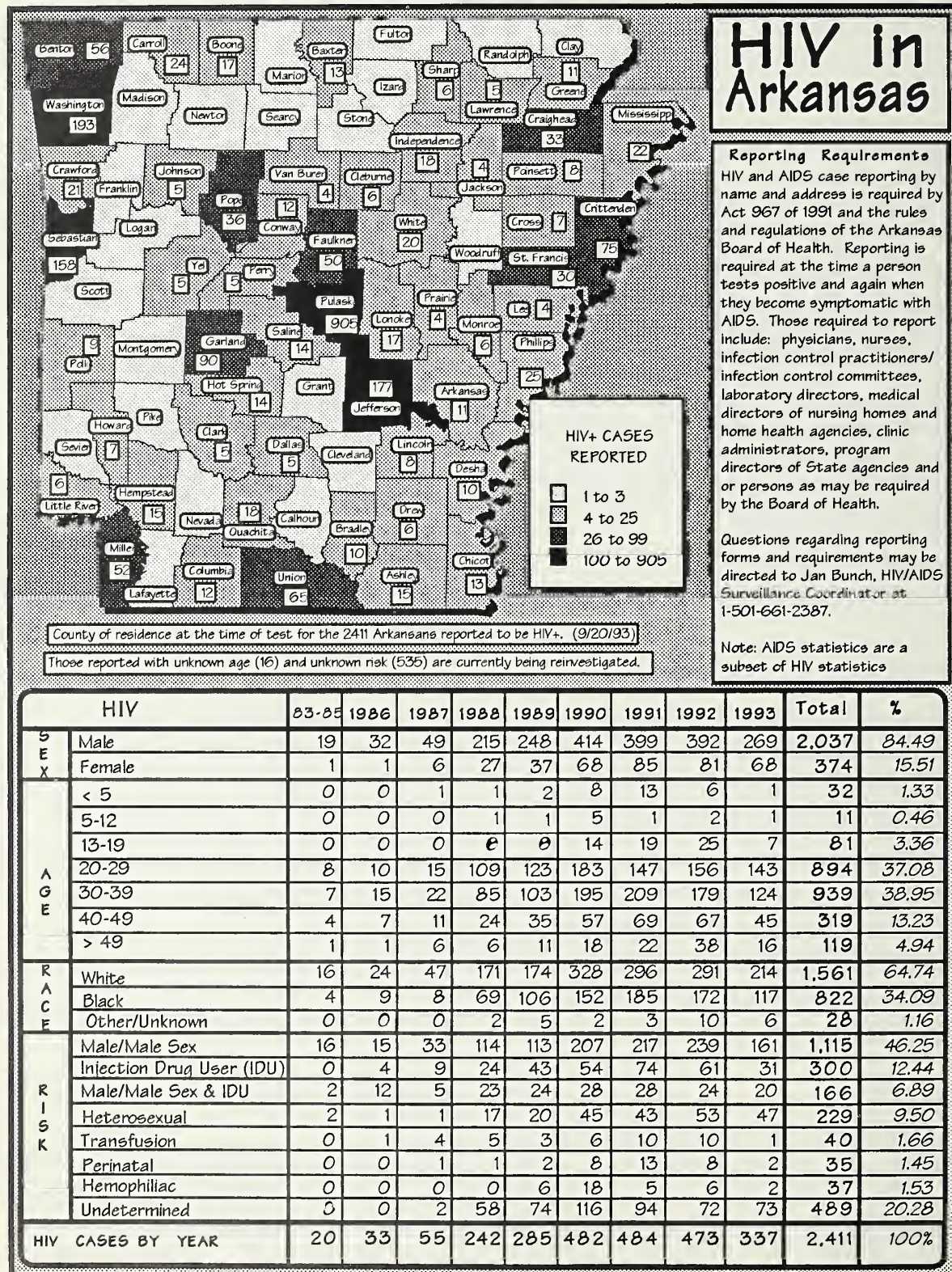
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## ATTENTION, AMS MEMBERS

Dues statements were mailed the first week of November. Your prompt response is appreciated.



# Arkansas HIV/AIDS Report 1983-1993

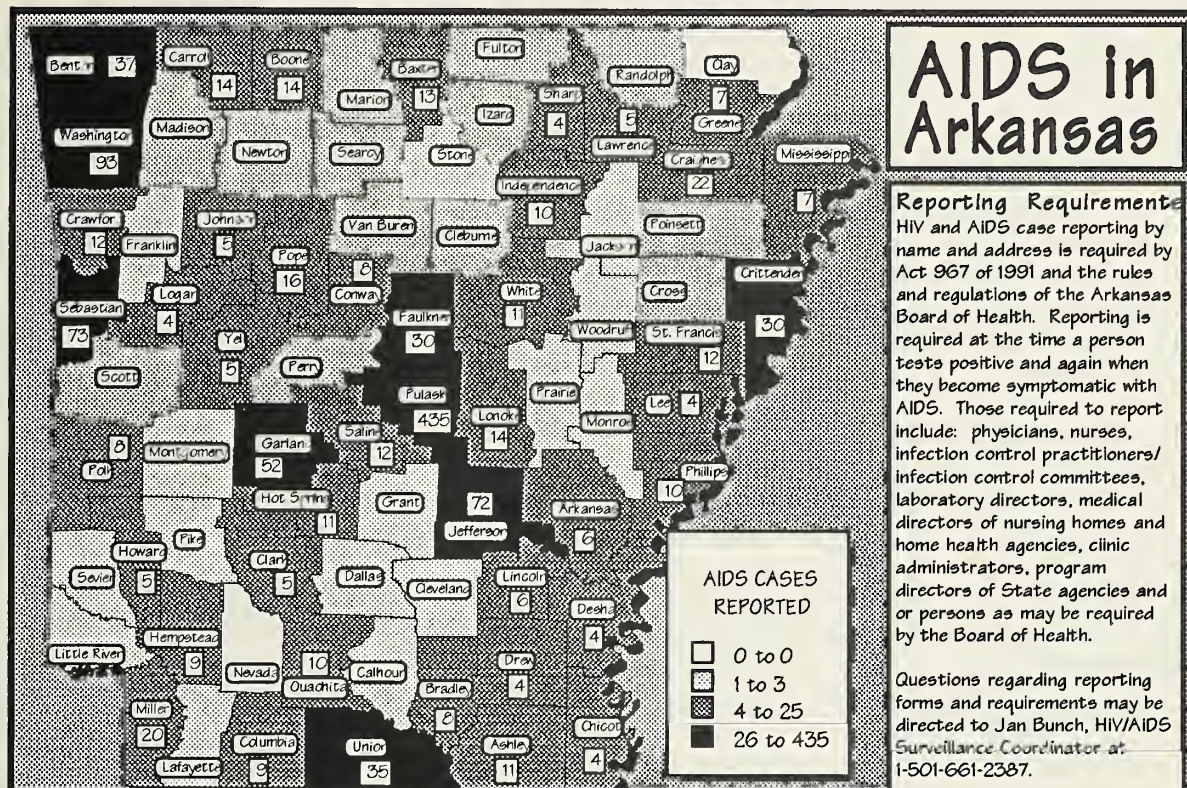


Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1993



Of the 2411 Arkansans reported to be HIV+, 1254 have been diagnosed with AIDS. (9/20/93)

AIDS		83-85	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	272	1,100	87.72
	Female	1	0	4	6	10	20	25	35	53	154	12.28
AGE	< 5	0	0	0	1	1	6	6	3	0	17	1.36
	5-12	0	0	0	1	0	1	1	0	1	4	0.32
	13-19	0	0	0	0	0	4	3	2	4	13	1.04
	20-29	7	9	15	27	24	55	57	81	88	363	28.95
	30-39	3	13	23	36	41	78	80	128	146	548	43.70
	40-49	1	6	8	10	7	35	41	52	63	223	17.78
	> 49	1	0	4	8	7	11	13	19	23	86	6.86
RACE	White	9	22	43	61	58	141	134	207	226	901	71.85
	Black	3	6	7	20	21	47	66	74	95	339	27.03
	Other/Unknown	0	0	0	2	1	2	1	4	4	14	1.12
RISK	Male/Male Sex	7	17	31	59	50	120	120	178	177	786	62.68
	Infection Drug User (IDU)	0	2	10	4	11	18	29	43	20	137	10.93
	Male/Male Sex & IDU	3	9	4	6	6	18	17	18	47	128	10.21
	Heterosexual	2	0	2	3	6	10	9	25	35	92	7.34
	Transfusion	0	0	2	7	3	7	11	3	2	35	2.79
	Perinatal	0	0	0	1	1	6	6	3	1	18	1.44
	Hemophiliac	0	0	0	1	1	5	5	4	5	21	1.67
	Undetermined	0	0	1	2	2	6	4	11	38	74	5.90
AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	325	1,254	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# New Members

---

## CHEROKEE VILLAGE

**Helmling, Robert L.**, Urology. Medical education, University of Cincinnati, 1963. Internship, Harbor General, Torrance, California, 1964. Residency, University of Cincinnati-General Hospital, 1968. Board certified.

## EL DORADO

**Vora, Shailesh C.**, Psychiatry & Neurology. Medical education, Seth GS Medical College, Bombay, India, 1982. Internship, K.E.M. Hospital, 1982. Residency, LSU School of Medicine and University of Minnesota, 1989. Board certified.

## FAYETTEVILLE

**Long, Robert M.**, Child & Adolescent Psychiatry. Medical education, University of Texas Medical Branch, Galveston, 1974. Residency, University of Texas Medical Branch, 1977.

**Reese, Valerie F.**, Family Medicine. Medical education, UAMS, 1990. Internship/Residency, AHEC-Northwest, Fayetteville, 1993.

## FORT SMITH

**Dotson, Richard A.**, General/Industrial Medicine. Medical education, College of Osteopathic Medical of Oklahoma State University, Tulsa, 1982. Internship, Oklahoma Osteopathic Hospital, Tulsa, 1983.

## HARRISON

**Langston, James D.**, General Surgery. Medical education, UAMS, 1988. Internship/Residency, UAMS, 1993.

## HOT SPRINGS

**Rayburn, John M.**, Emergency Medicine. Medical education, UAMS, 1990. Internship/Residency, UAMS, 1993. Board eligible.

## JONESBORO

**McKee, Sanders B.**, Family Practice. Medical education, St. George's University, School of Medicine, Grenada, 1987. Residency, 1993. Board pending.

**Sneed, Jane M.**, Pediatrics. Medical education, University of Tennessee, Memphis, 1989. Internship/Residency, University of Tennessee, 1992. Board certified.

## LITTLE ROCK

**Allison, Janice W.**, Diagnostic Radiology. Medical education, UAMS, 1987. Internship/Residency, UAMS 1992. Fellowship, Cincinnati, 1993. Board certified.

**Carter, Inge R.**, Family Practice. Medical education, UAMS, 1988. Internship, University of Tennessee, 1990. Residency, UAMS, 1993. Board certified.

**Matchett, W. Jean**, Radiology. Medical education, UAMS, 1988. Internship/Residency, UAMS, 1993. Board certified.

**Rice, Robert L.**, Psychiatry. Medical education, World University, Santo Domingo, Dominican Republic, 1984. Internship/Residency, UAMS, 1988. Board eligible.

**Salmeron, Manuel I.**, Family Practice. Medical education, University of San Carlos, Guatemala, 1980. Internship/Residency, UAMS, 1985. Board certified.

**Sharkey, Paul C.**, Pediatrics. Medical education, University of Texas Medical Branch, Galveston, 1989. Internship/Residency, Arkansas Children's Hospital, 1993. Board pending.

**Tutton, James E.**, Emergency Medicine. Medical education, University of Florida, Gainesville, 1973. Internship/Residency, University of Florida, 1976. Board certified.

**Willis, Charlotte R.**, Pediatrics. Medical education, Louisiana State University, Shreveport, 1990. Internship/Residency, Arkansas Children's Hospital/UAMS, 1993. Board eligible.

## LONOKE

**Thorn, Garland M., Jr.**, Family Practice. Medical education, UAMS, 1990. Internship, University of Oklahoma College of Medicine, Tulsa, 1991. Residency, Anderson Memorial Hospital, Anderson, South Carolina, 1993. Board pending.

## PARAGOULD

**Laffoon, Scott L.**, Family Practice. Medical education, UAMS, 1990. Internship/Residency, AHEC-Northeast, Jonesboro, 1993. Board pending.

## PINE BLUFF

**Jones III, James B.**, Family Practice. Medical education, UAMS, 1981. Internship, University of Tennessee, Knoxville, 1982. Residency, University of Oklahoma Health Sciences Center, Oklahoma City and AHEC-Pine Bluff, 1989. Board certified.



## PRESCOTT

**Young, Michael C.**, Family Practice. Medical education, UAMS, 1975. Internship, UAMS, 1975. Board certified.

## ROGERS

**Lanier, Karen A.**, OB/GYN. Medical education, University of Oklahoma, Oklahoma City, 1987. Internship/Residency, Louisiana State University, New Orleans, 1991. Board certified.

## SHERWOOD

**Collins, Kevin J.**, Physical Medicine & Rehabilitation. Medical education, University of Southern California School of Medicine, Los Angeles, 1989. Internship/Residency, University of Cincinnati Medical Center, 1993. Board eligible.

## SILOAM SPRINGS

**Lewis, Rebecca C.**, Family Practice. Medical education, Oklahoma State University College of Osteopathic Medicine, Tulsa, 1986. Internship, Doctors Hospital, Groves, Texas, 1987. Residency, Earl K. Long Charity Hospital, Baton Rouge, Louisiana, 1990. Board certified.

## SPRINGDALE

**Jones, Edwin C.**, Psychiatry. Medical education, UAMS, 1971. Internship/Residency, UAMS, 1975. Board certified.

## WEST MEMPHIS

**Westmoreland, Daniel K.**, Radiology. Medical education, University of Tennessee Medical School, Memphis, 1969. Internship, Orange Memorial Hospital, Orlando, Florida, 1971. Residency, David Grant Medical Center, California, 1975. Board certified.

## RESIDENTS

**Bishop III, Joseph R.**, Ophthalmology. Medical education, UAMS, 1993. Internship, UAMS. Residency, Medical University of South Carolina, Charleston.

**Brady, John G.**, General Surgery. Medical education, University of New Mexico, Albuquerque, 1992. Internship, University of Texas, San Antonio, 1993. Residency, UAMS.

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**Yazdani, Aijaz A.**, Internal Medicine. Medical education, Liaquat Medical College, Jamshoro (Sindh) Pakistan, 1971. Internship/Residency, UAMS.

## STUDENTS

Rodney C. Charles  
James B. Cotner

Yolanda R. Lawson  
Arlean M. Robertson-Bullard

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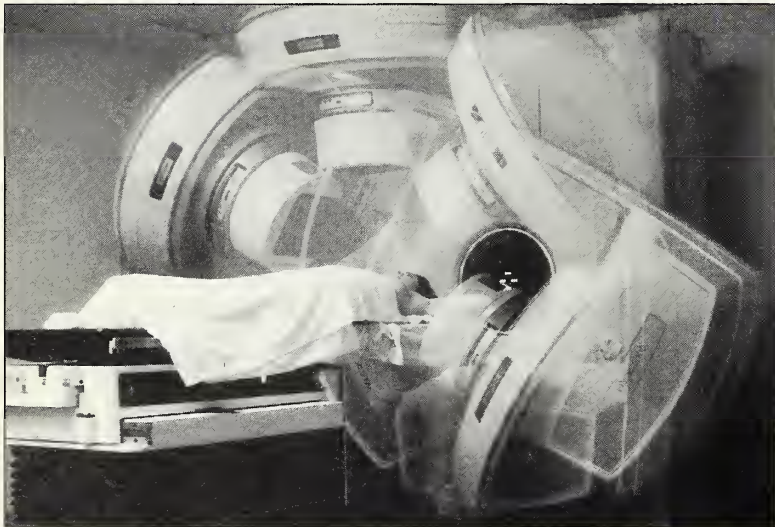
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The American Cancer Society, the American College of Surgeons and the American College of Radiology have agreed that women whose early breast cancer was detected by mammography are candidates for breast-saving treatment. According to new standards, women with small lumps, those with tumors as large as two inches, and even some women with positive nodes may be candidates for this treatment.

Stage for stage, patients treated in this manner have the same longevity and the same freedom from local recurrence as those treated with mastectomy.

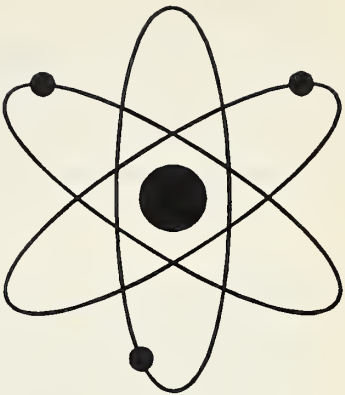
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For copies of the standards please contact  
Keri Sperry, American College of Radiology,  
1891 Preston White Drive, Reston, VA 22091.



# Radiological Case of the Month



David L. Harshfield, M.D.  
Joseph A. Norton, M.D.  
Kelly Grigg, B.S.

## History:

This patient was a 75-year-old male who presented with acute abdominal pain with no history of recent surgery or hospitalization. An acute abdomen series was obtained on March 24, 1989.

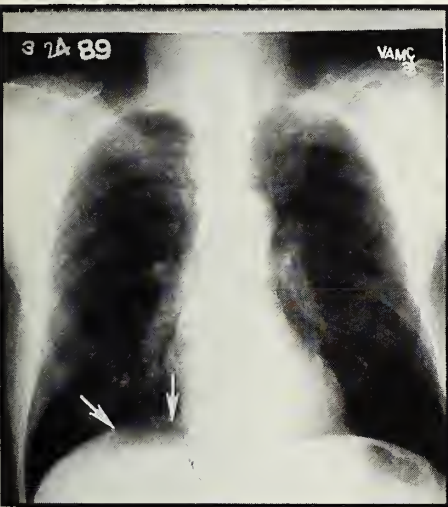


Figure 1



Figure 2

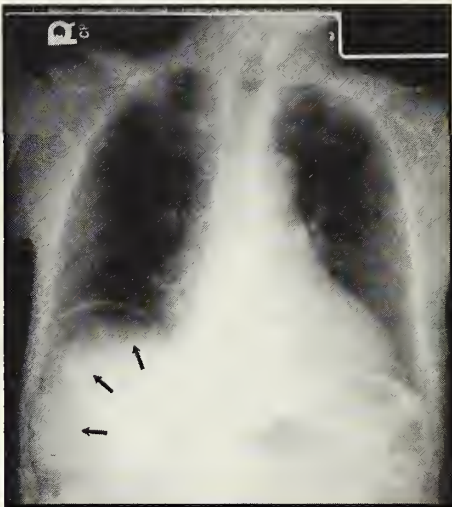


Figure 3

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# Chilaiditi's syndrome.

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## Findings:

The supine and erect abdominal films were unremarkable. The PA chest film however, (Fig. 1) had a suspicious infradiaphragmatic air collection along it's medial border (white arrows). The lateral film from that same study revealed an air collection under the anterior aspect of the right hemidiaphragm (Fig. 2, white arrows). The possibility of free intraperitoneal air was entertained. A left lateral decubitus film was obtained with the x-ray beam centered over the liver (not shown) which did not reveal free intraperitoneal air. Ultimately, a film was obtained from 1985 (Fig. 3) which revealed to even better advantage considerable air in the hepatic flexure of the colon (black arrows) mimicking free intraperitoneal air.

## Discussion:

An acute abdominal series generally consists of an erect PA and lateral chest film along with a supine and erect abdominal study. The terminology supine or erect abdominal film supplants the antiquated and less accurate terms "flat plate of the abdomen" or "KUB". Many years ago before x-ray film, abdomen studies were obtained by a process similar to photographs of that era with the image captured by an emulsion on a plate of glass. The term "wet reading" which is still with us today, was coined from the fact that emergency interpretations were obtained from a plate still dripping with water from the development process. The term KUB is from the indication for performing the abdominal film; that is to see the kidneys, ureters, and bladder. Interestingly enough, those are three structures that you can't see without administering intravenous contrast (IVP). You could detect, however, calcified stones when present in the genito-urinary system. Equally outdated terms in chest radiography are lung "fields" and costophrenic "angles" which are now termed "lungs" and "sulci" respectively.

Occasionally, very small collections of intraperitoneal air may not be visualized on the abdominal portion of the acute abdomen series but instead may be seen just beneath the hemidiaphragm on the erect PA chest film. This patient was suspected of having free intraperitoneal air based on his chest film, however, a left lateral decubitus film with x-ray beam centered over the liver was negative (see *The Journal of the Arkansas Medical Society*, Radiology Case of the Month, Sept. 93 for more detailed technique). A chest film from four years earlier revealed this patient to have the hepatic flexure insinuated superiorly between the liver and the anterior abdominal wall producing this interesting radiographic pattern.

Hepatodiaphragmatic interposition of the intestine is a rare anomaly (0.25 to 0.28 percent of the general population) described by Chilaiditi in 1911. Although this is believed to be of little clinical significance recent reports in the literature indicate that this syndrome is a potential source for abdominal problems some of which require urgent or elective surgery to correct. There are 356 cases reported in the world literature. The syndrome has been described to be most common in patients fifty years of age or older. It appears to be more prevalent in the male population. No



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subjective symptoms specific to Chilaiditi's syndrome have been described. There have been various factors postulated for the occurrence of the syndrome however, symptoms with this process are primarily based on underlying diseases such as intra abdominal malignancies ascites, or metabolic problems. Chilaiditi's syndrome is typically asymptomatic and is probably more common than reported in the medical literature. Symptoms occurring primarily from the Chilaiditi's syndrome most often respond to conservative management. The key point is that this syndrome can be mistaken for more serious abnormalities such as free intraperitoneal air, subphrenic abscess, etc., which could lead to unnecessary surgical intervention if the appropriate diagnosis is not made.

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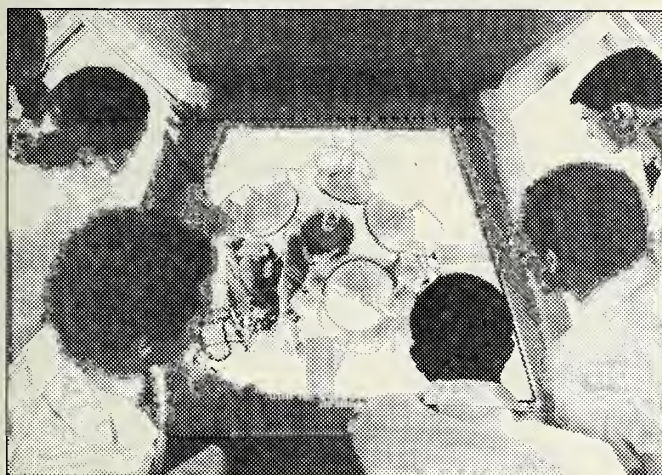
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*Editor: Dr. David Harshfield is Chief, Radiology Service at the Veterans Administration Hospital in Little Rock, and Director of Radiology at Riverside Radiology Group in North Little Rock.*

*Contributor: Dr. Joseph A. Norton is Professor of Radiology at University of Arkansas for Medical Sciences in Little Rock.*

*Contributor: Kelly Grigg is a premedical student research assistant at the University of Arkansas for Medical Sciences in Little Rock.*

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# AMS Newsmakers

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**Dr. Banks Blackwell**, Pine Bluff, Medical Director of the Orthopaedic Research and Education Foundation, has announced the appointment of 25 colleagues to serve in the Foundation's annual fund-raising campaign. Their focus is on soliciting other orthopaedic surgeons to join the Foundation's Order of Merit with contributions of \$1,000 or more.

The following AMS members are serving as Chairmen this year in Arkansas: **Drs. William F. Blankenship, William A. Runhan, David G. Newbern, C. Lowry Barnes, Carl L. Nelson, Jr. and Edward R. Weber**, Little Rock; **Drs. James H. Buie, Claude L. Martimbeau and Paul L. Raby**, Fort Smith; **Drs. James A. Arnold and Walter Duke Harris**, Fayetteville; **Dr. Dennis W. Luter**, Jonesboro; **Dr. Thomas P. Rooney**, North Little Rock; **Dr. Terry G. Green**, Searcy; **Dr. Thomas S. Roberts**, Conway; **Dr. John S. Duncan**, Benton; **Dr. James M. Kolb, Jr.**, Russellville; **Dr. Thomas E. Knox**, Mountain Home; **Dr. Charles A. Ledbetter**, Harrison; **Dr. Oscar L. Henderson**, Rogers; and **Dr. Stuart B. McConkie**, Hot Springs.

**Dr. Asa Crow**, Paragould, has been selected for Arkansas State University's 1993 Distinguished Alumni honor. He attended ASU for three years before earning his doctor of medicine degree at UAMS.

**Dr. Jim English**, of Little Rock, served on the certification board of the American Board of Facial Plastic and Reconstructive Surgery Inc. in Washington. The ABFPRS is a nonprofit corporation established in 1986 to improve the quality of medical and surgical treatment available to the public. Dr. English, who operates English Facial Plastic Surgery Clinic at Baptist Medical Center, participated in a peer review of the certification candidates' clinical practice experience.

**Dr. Robert R. Gullett Jr.**, Pine Bluff, was recently presented with the 1993 Lester Silbernagel Award by Dr. Willis B. Alderson, superintendent of the Pine Bluff School District and Glenda Langston, president of the Pine Bluff School Board. Dr. Gullett has been the Pine Bluff Zebras football team doctor for the past 16 years. The award is given annually to a private citizen who has contributed to public education, specifically within the Pine Bluff School District.

**Dr. Morriss Henry** of Fayetteville was one of 150 physicians from throughout the United States who attended a meeting at the White House recently after being invited by President Clinton and Hillary Clinton

to discuss the President's proposed health care program. Following the meeting, Dr. Henry attended a national conference on eye care that brought together leaders of the American Academy of Ophthalmology, the American Academy of Optometry, The American Medical Association, the National Eye Institute and representatives of the government.

**Dr. Ralph F. Joseph**, Ralph Joseph Clinic of Walnut Ridge, was recently appointed to the Commission For Arkansas' Future by Gov. Jim Guy Tucker. The Commission was established to develop and coordinate, with the involvement of the people of the state, an ongoing and comprehensive long-range process that encourages economic growth, human resource development and the improvement of the quality of life.

**Dr. Betty A. Lowe**, Arkansas Children's Hospital, was recently named by Worthen Banking Corporation, as one of the four 1993 Arkansas Professional Women of Distinction award winners. Worthen Banking Corporation's Professional and Business Women's Advisory Board selected the winners based on their professional accomplishments and community involvement. Dr. Lowe, along with the other three winners, will be honored November 10 at the seventh annual Arkansas Professional Women of Distinction Banquet at the Excelsior Hotel in Little Rock.

**Dr. Robert Miller Jr.** of Helena has been selected to receive the 1993 Arkansas Hospital Distinguished Service Award. Dr. Miller has practiced medicine in Helena for the past 28 years.

**Dr. Steven W. Strobe**, Little Rock, was recently installed as President of the Arkansas Academy of Family Physicians. **Dr. William D. Dedman**, Camden, was voted President Elect. **Dr. Linda A. McGhee**, Fayetteville, was installed as Vice President, and **Dr. Michael C. Young**, Prescott, as Treasurer.

**Dr. Alonzo D. Williams Sr.**, of Little Rock, has been selected as the 1993 Physician of the Year by the Arkansas Medical, Dental and Pharmaceutical Association. Dr. Williams is the secretary for the Arkansas State Medical Board and has a practice in gastroenterology.





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**I**n Arkansas, hundreds of physicians, pharmacists, dentists, home health agencies, hospitals and public health agencies have joined forces to support the Arkansas Health Care Access Foundation, Inc. (AHCAF). These providers are part of a unique voluntary effort to provide access to quality health care for low-income Arkansans who do not qualify for government assistance, have no form of health insurance and are living at or below the federal poverty level.

**You can help!** Thousands of Arkansans are potentially eligible for this safety net program. Therefore, continued support from all sectors of the health care community is essential if we are to meet the growing demand. Volunteering your services ensures timely medical attention for those in need. **You make a difference!**

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**Arkansas Health Care  
Access Foundation, Inc.**

## Health Care Access Foundation Update

As of October 1, 1993, the Arkansas Health Care Access Foundation has provided free medical service to 6,577 medically indigent persons, received 12,718 applications, and enrolled 25,952 persons.

The program has 1,646 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

## Special Announcement From the IRS: Reinstatement of Vaccine Tax

The Omnibus Budget Reconciliation Act of 1993 has reinstated the vaccine excise tax, effective August 11, 1993. The taxable vaccines and the tax rates are as follows:

<u>Vaccine</u>	<u>Tax Per Dose</u>
DPT (diphtheria, pertussis and tetanus)	\$4.56
DT (diphtheria-tetanus)	.06
MMR (measles, mumps and rubella)	4.44
Polio	.29

The Act provides for a floor stocks tax on the taxable vaccines. The floor stocks tax applies to any person who held a taxable vaccine for sale or use on August 10, 1993. There are no exceptions to this tax. Therefore, hospitals, doctors, Federal, state, and local governments, and other purchasers of vaccines will be subject to the floor stocks tax if they held these vaccines in inventory on August 10, 1993. The vaccines must have been purchased on or before August 10, 1993, without tax imposed under section 4131 of the Internal Revenue Code.

The tax was dropped off the price by the manufacturer from January 1, 1993 through August 10, 1993. With the reinstatement, taxes are owed on all floor stocks held on August 10, 1993 that were purchased during that time period.

Any person who held a taxable vaccine on August 10, 1993, must make an inventory of the number of doses in stock at that time. (There may be a floor on the tax where small inventories are exempt however, even if this is the case, you must have a record.) The vaccine floor stocks tax must be paid by February 28, 1994, and will be reported on Form 720, Quarterly Federal Excise Tax Return.

## State Awarded Funds to Help Reduce Tobacco Use

The Centers for Disease Control and Prevention (CDC) has awarded the state \$82,807 for the first year to help Arkansas health professionals reduce tobacco use and fight smoking-related deaths and disease for the next five years. This is part of the CDC's new nationwide tobacco control program. The funding will be used to provide information and education, training, assistance and resources to state and local tobacco-control activities in Arkansas.

In 1990, the last year for which data is available, the total economic cost of smoking in Arkansas was over \$728 million. A total of 1,871 Arkansans died of lung cancer in 1991, an average of 5 every day.

## New Device at AMI is First For U.S.

AMI National Park Medical Center, Hot Springs, recently purchased the new digital Advantx AFM system, a vascular imaging device, from G.E. Medical Systems.

It cost around \$1.2 million, and AMI is the first hospital in the nation to have one up and running on a non-experimental basis.

AMI's device is the second in the world with a computer upgrade to assist its imaging capabilities. The only other similarly equipped device is in France.

Advantages of the new device include: cutting the amount of iodine injected into the patient by a third; procedures that took four or five minutes before now take about 15 seconds; the quality of the images is greatly improved; the images are printed on film, but they can also be stored on computer and viewed on a video screen; and the patient receives less radiation because this device pulses X-rays through the body, instead of subjecting it to a steady stream of radiation.

The system's strengths, according to Paulette Johnson, AMI medical imaging director, are in abdominal, neurological and peripheral vascular imaging. It can detect life-threatening disorders such as blood clots, hardening of the arteries and kidney disease, and can be used in the assessment of strokes.

## Arkansas Foundation for Medical Care, Inc. Appoints New Medical Director

Dr. James D. Armstrong, Chairman, Board of Directors for the Arkansas Foundation for Medical Care, recently announced that the board has concluded its



search for a Medical Director with the appointment of Dr. Kevin J. Kenny.

Dr. Kenny is board certified in Family Practice and operated a successful family practice for 30 years. For the last five years, he has been Assoicate Medical Director for KePRO, the PRO contractor for Pennsylvania which is a subsidiary of the Pennsylvania Medical Society. He has been extensively involved in direct patient care as well as having substantial PRO medical director experience.

The board wishes to express special thanks to Dr. Morton C. Wilson for serving as acting medical director for several months.

Dr. Kenny, who assumed his duties in October, is looking forward to getting around to all the areas of the state as soon as possible to meet you.

**Some CHAMPUS Maximum Allowable Charges Reduced**

The Defence Department will soon reduce some CHAMPUS maximum allowable payments to physicians and other individual professional providers (including clinical laboratories), to more closely match Medicare fees.

For services rendered on or after Nov. 1, 1993, medical procedures for which the prior year's national CHAMPUS Maximum Allowable Charge (CMAC) exceeds the Medicare fee will be reduced by the lesser of: 1) the amount by which it exceeds the Medicare fee; or 2) 15 percent.

Providers of care who want to know if the CMAS for a particular procedure has been reduced may contact the CHAMPUS contractor for their state.

**CHAMPUS Sets Balance Billing Limits**

Providers of care who don't participate in CHAMPUS (also called "accepting CHAMPUS assignment") will be limited in how much they can bill CHAMPUS patients, beginning next calendar year.

For services provided on or after Jan. 1, 1994, the Department of Defense Appropriations Act of 1993 says that providers who don't participate may bill CHAMPUS patients no more than 115 percent of the CHAMPUS allowable charge for a particular service. The 115 percent limit is the same as that used by Medicare.

Providers who don't comply with the limit on charges could lose their status as authorized providers of care under CHAMPUS.

**In Memoriam**

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**Lee F. Beamer, M.D.**

Dr. Lee F. Beamer, of Hot Springs, died Saturday, October 7, 1993. He was 59.

Survivors include his wife, Nijole Beamer, of Hot Springs.

**Robert A. Fisher, M.D.**

Dr. Robert A. Fisher, of Little Rock, died Monday, October 11, 1993. He was 36.

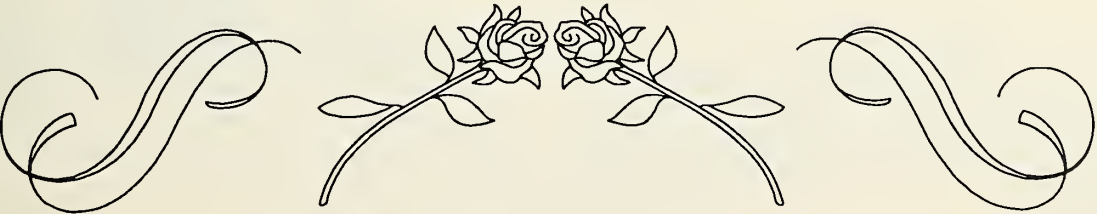
Survivors include his mother, Pansy T. Fisher, of Little Rock, an uncle, and several cousins.

**Henry V. Kirby, M.D.**

Dr. Henry V. Kirby, of Harrison, died Tuesday, September 21, 1993. He was 85.

Dr. Kirby was a past president of the 50 Year Club of the Arkansas Medical Society.

Survivors include his wife, Marilyn Kirby, of Harrison; a son, Henry Hudson Kirby of Fort Smith; a daughter, Helen Vance Kirby Daniel of Augusta; another step-son, Vincent Magdefrau of Sunnyvale, Calif.; two step-daughters, Victoria Magdefrau of Harrison and Susan Magdefrau of Memphis; a sister, Hazel West of Edmonds, Washington; seven grandchildren and one great-grandchild.



# Things To Come

---

## December 3-4

**Head and Neck Oncology; Otolaryngology Seminar Series.** Inter\*Continental Hotel, New Orleans. Sponsored by Tulane University Medical Center, Dept. of Otolaryngology-Head and Neck Surgery and the office of CME. For more information, call (504) 588-5466.

## December 3

**Women's Healthcare Issues '93.** The Ritz-Carlton Hotel, St. Louis, Missouri. For more information, call the Office of CME, Washington University School of Medicine at (800) 325-9862.

## December 4

**Current Management of Hepatic and Biliary Disease.** The Ritz-Carlton Hotel, St. Louis, Missouri. For more information, call the Office of CME, Washington University School of Medicine at (800) 325-9862.

## December 9-11

**Women: Face to Face with HIV.** Sponsored by the Delta Region AIDS Education and Training Center, with the National Institutes of Health and others. For information, call Daphne LeSage at (504) 568-3855.

## December 11

**Biotherapy for Solid Tumors.** UC Davis Medical Center, Cancer Center Auditorium, Sacramento, Calif. For information call the Office of CME at (916) 734-5390.

## December 11

**Cardiology Seminar.** The Ritz-Carlton Hotel, St. Louis, Missouri. For more information, call the Office of CME, Washington University School of Medicine at (800) 325-9862.

## January 14-15

**What's New in General Surgery: 16th Annual Surgical Postgraduate Course.** Hyatt Regency, Sacramento, Calif. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## January 16-18

**Ambulatory Obstetrics and Gynecology.** Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## January 22

**Current Concepts in Hemostasis and Thrombosis.** Cancer Center Auditorium, UC Davis Medical Center, Sacramento, California. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## January 23-26

**Fracture Management.** Resort at Squaw Creek, Squaw Valley, Calif. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## January 23-28

**20th Annual Midwinter Program in Continuing Medical Education for Psychiatrists.** Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Office of CME at UC Davis School of Medicine and Medical Center. For information, call (916) 734-5390.

## January 28-29

**Transfusion Medicine: Update 1994.** Seattle, Washington. Sponsored by the American Association of Blood Banks (AABB). For more information, call (301) 215-6482.

## January 29

**Advances in Cardiology.** Le Meridien Hotel, New Orleans, Louisiana. Sponsored by The Section of Cardiology in the Department of Medicine, and the Tulane University Medical Center, Office of CME. Six hours Category I credit offered. For information, call (504) 588-5466.

## January 29

**General Medicine Update for the Ophthalmologist.** Cancer Center Auditorium, UC Davis School of Medicine and Medical Center. Approx. 6 hours Category I credit offered. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## February 26

**Cardiology for the Primary Care Physician.** Cancer Center Auditorium, UC Davis School of Medicine and Medical Center. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.



# **The Hospital Medical Staff Section 22nd Assembly Meeting December 2 - 6, 1993 Hyatt Regency New Orleans**

HMSS representatives won't want to miss this year's AMA-HMSS Interim Assembly Meeting. They will have an opportunity to learn about and discuss with AMA's leadership and staff the details of President Clinton's health care reform proposal as well as AMA's legislative strategy.

HMSS representatives will also be presented with an overview of physician and physician/hospital organizations, including the physician hospital organization, management services organizations, the foundation and physician equity models, and the hospital-affiliated professional corporation.

## **Review and analysis of President Clinton's Health Care Reform Plan**

President Clinton released his new health care reform plan in September. HMSS representatives in this session will hear a full review and analysis of the plan.

## **Physician Organizations & Hospital Organizations**

Henry E Golembesky, MD, director of Integrated Health Systems Practice of American Practices Management and former chief executive officer of UniMed America, will discuss and examine, from a physician's perspective, the advantages and disadvantages of the organizational structures being created in response to federal, state, and business health care reform initiatives. He also will identify the key elements of successful physician and physician/hospital organizations.

Dr Golembesky will be joined by several physicians who currently practice in these structures. They will share their experiences and cite the challenges and opportunities for physicians. HMSS representatives will be able to ask questions of the physician panelists and together explore mechanisms to maintain physician control in the credentialing of network providers, the monitoring and assessment of patient care, and the setting of quality of care standards/outcomes.

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help your physician community succeed!**

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## **Hospital Medical Staff Section**

## **American Medical Association**

Physicians dedicated to the health of America



# Keeping Up

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## **Diagnosis and Treatment of Active Duodenal Ulcer**

*November 18, 12:00 p.m.-1:30 p.m., Medical Center of South Arkansas, Conference Room 3, El Dorado. Presented by Dr. Fred M. Sutton, Gastroenterology, Baylor, and sponsored by AHEC-South Arkansas. Category I credit: 1 hour.*

## **Women in Medicine Day "Empowering Women"**

*November 18, 8:00-8:30 a.m. registration & coffee, Sturgis Auditorium, Arkansas Children's Hospital, Little Rock. Sponsored by UAMS and presented by Dr. Debra Fiser. Category I credit offered: 3.75 hours.*

## **Surgery for Cleft Lip and Cleft Palate**

*November 18-21, time to be announced, Arkansas Children's Hospital Conference Center, Little Rock. Spon-*

*sored by UAMS College of Medicine and presented by Dr. Robert Seibert. Category I credit offered: 17.25 hours.*

## **Infectious Disease**

*December 9, 12:00 p.m.-1:30 p.m., Medical Center of South Arkansas, Conference Room 3, El Dorado. Presented by Dr. Terry Yamauchi, UAMS Outreach Program and sponsored by AHEC-South Arkansas. Category I credit: 1 hour.*

## **Annual Physician Update**

*February 12, 1994, 7:30 a.m. - 3:30 p.m. (approx.), Center for Health Education, St. Vincent Infirmary Medical Center, Little Rock. Sponsored by St. Vincent Infirmary Medical Center and presented by the Office of Continuing Medical Education.*

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **FAYETTEVILLE-VA MEDICAL CENTER**

*Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*Continuing Medical Education Luncheon, Dec. 10, Jan. 14 & 28, 12:30 p.m., AMI Ozark - Quapaw Room*

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom*

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.  
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Cancer Conferences, Thursdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.*



## **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*Breast Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*GI Conference*, 4th Friday, 11:30 a.m., Conference Room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

## **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Chest & Problems Case Conference*, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Medicine Conference*, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Surgery Conference*, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*X-ray Case Conference*, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102

*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

#### **EL DORADO-AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

#### **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

#### **FORT SMITH-AHEC**

*Advances in Plastic Surgery*, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Tuesdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center



**JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Harris Hospital Tumor Conference*, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

**PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

**TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, every other 3rd Wednesday, 12:30 p.m., St. Michael Hospital  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Residency Noon Conference*, Tuesdays, Wednesdays and Thursdays, 12:30 p.m., AHEC-Southwest Family Practice Clinic  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Board*, Fridays, except 5th Friday, 12:00 noon, Wadley Regional Medical Center & St. Michael Hospital  
*Tumor Conference*, every 5th Friday, 12:00 noon alternates between Wadley Regional Medical Center & St. Michael Hospital  
*AHEC Tumor Board*, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital



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## MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

Along with the typed manuscript, we encourage you to submit an IBM-compatible 5 1/4" or 3 1/2" diskette containing the manuscript in ASCII format. The manuscript on diskette must be in the same format as stated above. We will return the diskette upon request.

## REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the author(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

## ILLUSTRATIONS

Illustrations should be professionally drawn and/or photographed. Glossy black and white photos are preferred. They should not be mounted and should have the name of the author(s) and figure number penciled lightly on the back. An arrow should indicate the top of the illustration. In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material. Up to four illustrations will be accepted at no charge to the author(s). If more than four are necessary, it is understood that the author(s) will be responsible for the reproduction costs.

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## 1994 AMS Convention

### Highlights

The 1994 convention, "The Bases are Loaded... AMS' at Bat," will feature topics of interest to Arkansas physicians, including managed care, health care reform and AIDS.

Plan to visit over 75 companies exhibiting their products or services such as insurance, billing and collecting, pharmaceuticals, computer software, financial information and others.

National health care reform has generated tremendous interest by the medical community and we anticipate a record attendance at this meeting.

You will not want to miss the timely information discussed at the convention. See the schedule below and mark your calendar.

### CONVENTION "LINE-UP"

#### Thursday, April 7, 1994

- 8:30 a.m. Golf Tournament
- 1:00 p.m. Registration Opens
- 2:00 p.m. Council Meeting
- 3:30 p.m. Exhibits Open/Welcome Reception
- 5:00 p.m. House of Delegates
- 6:30 p.m. Blue Cross Blue Shield Reception

#### Friday, April 8, 1994

- 7:30 a.m. Council Meeting
- 8:30 a.m. Exhibits Open (Breakfast served)
- 11:00 a.m. First Session Speaker
- 12:30 p.m. Shuffield Lecture/Luncheon
- 2:15 p.m. Second Session Speaker
- 3:30 p.m. Exhibits Open (Refreshments)
- 6:30 p.m. "Take Me Out to the Ballgame" Party

#### Saturday, April 9, 1994

- 7:30 a.m. Council Meeting
- 8:00 a.m. Early Morning Refreshments
- 8:45 a.m. Third Session Speaker
- 10:30 a.m. House of Delegates
- 12:00 p.m. Fifty Year Club Luncheon
- 12:30 p.m. Specialties/Committees can elect to meet
- 6:00 p.m. Hospitality Hour
- 7:00 p.m. Inaugural Banquet
- 9:00 p.m. President's Dessert Reception

### A Winning Team

Dr. J. Larry Lawson of Paragould installs Dr. Glen F. Baker of Little Rock as the 1993-94 AMS President.



### Key Players



The "GroanUps" will perform during the "Take Me Out to the Ballgame" Party on Friday, April 8, 1994.

### Seventh Tuning Stretch

Participants at the 1993 Annual Session having fun at the Western Hoedown.



**118TH AMS ANNUAL SESSION  
EXCELSIOR HOTEL &  
STATEHOUSE CONVENTION CENTER  
APRIL 7 - 9, 1994**



# A Message From Your President

## AMS Announces Managed Care Initiative

Glen F. Baker, M.D.  
President, Arkansas Medical Society

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*"If the best interest of our patients is to remain paramount, we must act now to take the lead in reforming our health system."*

Glen F. Baker, M.D.  
Arkansas Medical Society President, 1993 - 1994

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Last April when I accepted the office of president of the Arkansas Medical Society, I stated my belief that it was imperative the AMS position itself to respond rapidly and in an informed manner to the evolving health reform environment. A committee on health system reform was organized and charged with three major goals.

1. Strategically position the Arkansas Medical Society as a force in shaping reform;
2. Maintain physician autonomy and control of medical practice; and
3. Develop proactive state/county, federal and medical practice responses to health system reform.

The Arkansas Medical Society staff and I immediately began visiting county medical societies and hospital medical staffs around the state. We also began collecting data from other states concerning reform efforts, managed care, and how physicians in those states were responding to these developments.

Our visits and research led us to a very obvious conclusion. By the time any significant reform legislation comes out of Washington, much of our health care system will have already been reformed by market forces - mainly in the form of managed care.

In many areas of the state, including rural communities, physicians are being pressured to sign managed

care contracts from a variety of entities. Tactics range from friendly persuasion to outright threats of busing patients to nearby communities. In Little Rock, the major hospitals are aligning with large insurers who are positioning themselves to dominate the health delivery system in our state.

With few exceptions, the current environment is being driven by insurance companies, managed care entities, and hospitals. The real threat is to our patients who are being relegated to descriptive labels such as "customers" and "market share". Employers are being forced into managed care plans by rising insurance costs. The result is that employees, our patients, are losing their freedom to choose their doctor. And, we as physicians are losing our freedom to act in the best interest of our patients.

It became apparent that for Arkansas' physicians to maintain autonomy and to control our own destiny it would be necessary to organize into efficient, economic entities, capable of competing on an even play-

During this same time period, Governor Jim Guy Tucker appointed the "Health Care Reform Task Force". The purpose of the task force is to develop options for an Arkansas response to any health reform legislation coming out of Washington D.C. The Arkansas Medical Society is well represented on the task force. In fact, of the 35 members on the task force, nine are physicians including Charles Logan, AMS Council Chairman and Glen Baker, AMS President. Other physician members are:

Mike Moody, Salem  
Joe Hargrove, Little Rock  
Sandra Nichols, Holly Grove  
John Bates, Little Rock  
Harry Ward, Little Rock  
James Weber, Jacksonville  
Andrew Kumpuris, Little Rock, Chairman



ing field with third-party managed care organizations. Physician support for the AMS to establish some type of statewide network in which all physicians would participate on an equal basis has been overwhelming.

## FEASIBILITY STUDY

But could we make it happen? To find out, the AMS Council, on June 27, gave our committee authority to develop recommendations for a statewide physician-sponsored, managed care organization. A feasibility study was commissioned to objectively assess the marketability of such an organization to Arkansas employers and if so what type of plan would best meet the needs of our membership. Loweth Enterprises, Inc., of Houston, Texas was selected to conduct the study. Bill Loweth, the company's founder, is locally known for his involvement in creating APPO, a very successful physician sponsored PPO in Pine Bluff, in existence for six years.

The major thrust of Mr. Loweth's study was to interview a wide variety of employers around the state; to determine their current benefit plans; satisfaction level; involvement or future involvement with managed care; and their attitudes towards the Arkansas Medical Society, physicians in general, hospitals, and private insurers. (The full report was presented to the AMS House of Delegates on November 7 and is reprinted at the end of this article.)

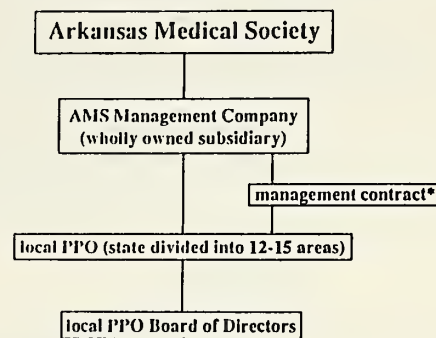
To summarize, the findings indicate that very little managed care exists outside the Little Rock area but employers see this changing rapidly in the very near future and, in fact, it is already changing. Their feelings and attitudes about Arkansas' physicians are very positive, specifically mentioning high quality and reasonable costs. Employers generally have a positive image of the Arkansas Medical Society, which can be attributed in part to the Arkansas Medical Society working with the state Chamber of Commerce on the Worker's Compensation fee schedule. On the other hand, the employers attitudes towards hospitals and insurance companies were much less positive. They feel that PPO's could work to their benefit and that it would be appropriate for the AMS to develop provider networks.

While the results of the study cannot guarantee success of any AMS plan, they certainly indicate that employers would look favorably on managed care plans sponsored by their local physicians.

## AMS DELEGATES APPROVE PLAN

Based on the results of the study a plan was developed and presented to the AMS House of Delegates on November 7. While many details remain to be worked out, the delegates gave their unanimous approval to proceed with great haste.

The plan calls for the AMS to support the development of a network of local PPO's across the state. This will be accomplished through a management company organized as a wholly-owned subsidiary of the AMS.



The management company will work with local physicians to establish their own local PPO. Through this PPO, the physicians and employers can develop a plan and product best suited to meet the specific needs of that community. In addition, the plan would create a statewide network of physicians. Statewide employers and insurers could then contract with the local PPOs and/or the statewide physician network, thereby avoiding the expense of establishing their own network. The AMS headquarters has already had several inquiries in this regard.

The AMS management company will provide all staff and services necessary to operate each local PPO through a central office. This will allow significant economies of scale thus enabling the AMS to serve the needs of very small physician communities as well as large areas such as Little Rock.

The management company will negotiate hospital and ancillary provider contracts for the local PPO's. It will also provide all marketing and administrative services from product development to coordination of utilization review and fee schedule development.

---

Each local PPO enters into a long term management contract with AMS Management Company. AMS Management Company will provide the following:

- Product Development
- Marketing
- Administration
- Management
- Physician member enrollment/orientation
- Physician office staff orientation
- Coordination of fee schedule and utilization review program
- Hospital contracting
- Ancillary services contracting
- Statewide employer contracting
- Statewide provider contracting
- Statewide and local contracting with:
  - Insurers
  - TPAS's
  - Managed care companies to "rent our network"
- Position us to be a lead participant in any government alliances

Of particular importance is the plan's reliance on local physicians and employers to come together to develop a local response to the community's health care needs. The role of the management company will be to facilitate development and provide management not to dictate what that local response must be. In fact, it should be clearly understood that the initiative for forming any local PPO must come from local physicians. If that desire is present, the Management Company will provide all professional and legal assistance to create the PPO and then proceed to manage it on an ongoing basis but under the guidance of a local physician/employer board.

## FINANCING

If this plan is to succeed, it must be adequately financed and backed by physician support and participation. Start-up costs include creation of the management company, staffing, office space, etc. It would not be prudent to proceed further unless physicians are willing to take this first step. Therefore, the Arkansas Medical Society will invest the first \$100,000 in start-up costs, with each physician then contributing \$300. If for any reason the management company is not formed the \$300 will be returned. For example, if physician interest is not adequate, as evidenced by a lack

of contributions, it would be foolish to hire staff and lease space. Assuming this first step is reached, ongoing financing will come from a fee (approximately \$2.00 to \$3.00) per employee per month, paid by participating employers to the management company.

It is now up to you. The leadership of our society feels strongly that this is the best avenue to insure that physicians remain the focal point of our health system. There are risks, but the potential success far outweighs them.

We physicians face what is probably the most important business decision of our lives; whether to turn over control of our practices to hospitals and entrepreneurs - or organize into economic entities which can effectively compete in the new managed care environment. A strong, state-wide organization operating locally by and through physicians and employers can accomplish this goal.

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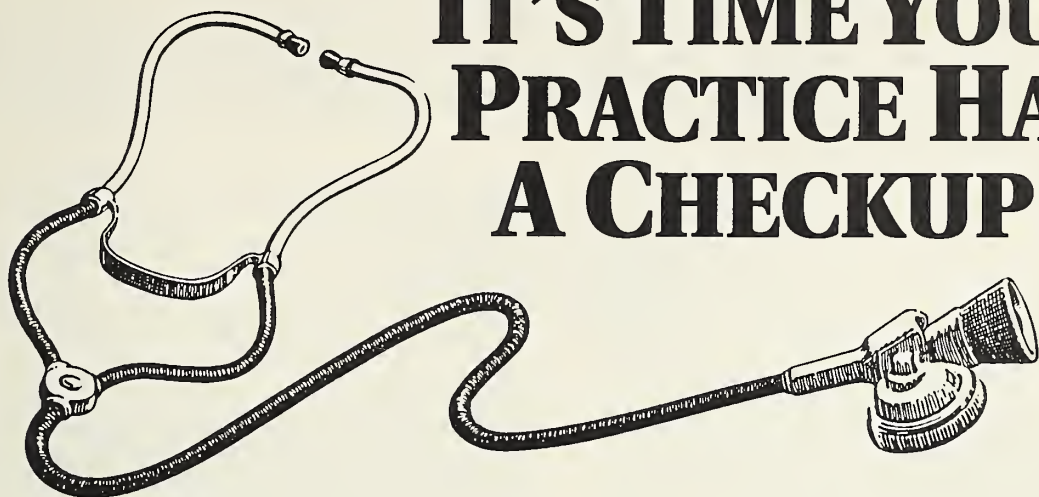
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- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Would your practice's rent or mortgage be paid?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your employees' salaries be paid?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your employees receive the benefits you promised them?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would installments or lease payments on office equipment be paid? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your professional liability insurance premiums be paid?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your property and casualty insurance premiums be paid?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your practice's taxes be paid?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your practice's utility bills be paid?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would professional or trade dues be paid?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your accounting, billing, and collection fees be paid?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your mailing and subscription costs be paid?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you checked "No" to any of these questions, your practice failed the checkup.  
But your practice doesn't have to suffer when you become disabled.

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# Managed Care Feasibility Study for the Arkansas Medical Society

Prepared by Loweth Enterprises, Inc.  
William B. Loweth  
November 1993  
Houston, Texas

This report is the result of a feasibility study undertaken by Loweth Enterprises, Inc. on behalf of the Arkansas Medical Society.

Loweth Enterprises, Inc. suggested to the society that any decision to initiate a managed care plan for member physicians should be preceded by a feasibility study. Specifically, we believe that any successful health care delivery system must meet the needs of employers who are the sponsors and principal payors of employee benefit plans. Therefore, the main thrust of this study was to identify and interview a wide variety of employers across the state of Arkansas, to determine their current benefit plan structure, their satisfaction or lack thereof with their current plan, their involvement with managed care or their anticipated involvement with a managed care plan in the future, and any thoughts they might have about the Arkansas Medical Society generally and physicians in particular.

These employer visits included four areas of the state: the Springdale/Rogers/Fayetteville area; the Ft. Smith/Van Buren area; the Pine Bluff area and the Little Rock area.

Before beginning our employer visits, we expressed some concern to the Arkansas Medical Society leadership about the appropriateness of a state society being the developer and manager of a managed care company. Specifically, the society probably does not have the staff, experience or capital to develop, market, administer and manage a major program. On the other hand, assuming the society can build a strong coalition of physicians across the state who will be willing to participate in a society sponsored program, this coalition could form the provider network component of a managed care plan, with the other components coming from an existing managed care company, insurer, or third party claims administrator (TPA), who would be experienced in product development, marketing, administration and management.

Early in the feasibility study we visited with several individuals in the state who own companies working in the employee benefit and managed care fields.

We presented our concept of a partnership between the medical society and another organization to test this concept and to develop it if they were aware of a potentially interested party. Having planted that seed, we proceeded ahead with individual employer visits.

Generally, our employer visits produced positive responses relative to both the Arkansas Medical Society and individual physicians throughout the state. For the most part, we found out that employers have indemnified plans without managed care but that larger employers definitely see changes coming in the near future. Large private insurers received mixed reviews and are not held in high esteem across the state. In fact, there is very little managed care activity today outside of the Little Rock area.

Specific provider inquiries produced very interesting results. Almost without exception, employers have positive feelings about physicians. They believe that physicians provide good quality medicine with reasonable costs and generally good access. The only negative on the physician side is that there are some rural areas where there are not enough physicians available to meet the needs of the rural population. One major employer is considering the establishment of several clinics of their own in the state to meet the primary needs of their employees and covered dependents located in medically underserved areas.

On the hospital side, we were quite surprised by employer reaction. The majority of employers we visited feel that hospitals in the state are generally uncooperative with them and overcharge for services. Some employers were extremely concerned about the duplication of services provided by competing hospitals in the same community. Employers feel that hospital costs are considerably higher than they should be when hospitals duplicate services and build the costs of those services into their charges. One large employer in Northwest Arkansas is so upset about this that they send cardiovascular patients out of the state rather than using either of two hospitals in their area who have open heart capacity.



Please note that our employer conversations were very frank and open. We believe it is important to protect the confidentiality of those discussions by not mentioning specific providers or employers. We look forward to visiting again with most of the employers we interviewed if the Arkansas Medical Society goes ahead with the development of a managed care delivery system.

While most employers do not have a thorough knowledge of the Arkansas Medical Society and its purposes, they generally have a positive feeling about the organization and the work it does on behalf of physicians throughout the state. Employers feel that it would be appropriate for the Arkansas Medical Society to be involved with managed care plans and to support one or more plans where the Arkansas Medical Society has developed the physician provider network. Generally, employers believe that PPOs could work in their benefit plans and could save money. Almost all employers outside of the Little Rock area feel that their management team and employees are not yet ready for a health maintenance organization delivery system. At the same time, many of them believe that HMO type medicine is inevitable in the intermediate future.

It became very clear from our trips to Arkansas that the state has two distinctly different areas - the Little Rock area (urban) and the rest of the state (rural). Further, we saw considerable differences in different rural areas of the state. In some areas, physicians and hospitals work well together whereas in other areas there seems to be more animosity than cooperation. After three trips around the state visiting with employers, it started becoming apparent to us that we might develop approximately twelve separate PPO organizations that would be linked by common administration and management, and that the PPO would resemble the organization established in Pine Bluff in 1987.

Indeed, our final trip included a day in the Pine Bluff area so as to visit the Arkansas Preferred Provider Organization there and to visit with several employers whose plans have included the APPO program for a number of years. What we found is that the Pine Bluff PPO model is working well and that it has stood the test of time over the past six years. It is fair to say that employers are very happy with the program and believe it is bringing cost and utilization control to their benefit plans. Physicians have found the need to slightly adjust the way they practice medicine in some instances but they have generally been pleased with their market share and their reimbursement. The hospital in Pine Bluff seemingly does not play an active role in the PPO but certainly should feel positive about it as the hospital maintains virtually all health care that it can provide, sending only some tertiary cases out of the area.

The PPO serving Pine Bluff is really quite simple and should be explained for the readers of this study.

The organization was put together via a partnership between the business community, physicians and the hospital. Each of these components is equally represented on the Board of Directors though only the physicians and hospital are stockholders. Physicians in the PPO have agreed to a fee schedule and a partial withhold of their fee. Employers agree to a predetermined expected claims level for their benefit plan each year. If at the end of the benefit plan year actual claims are less than expected claims, all physician withholds are paid to the physicians out of those funds. If there are still funds available after distribution of the withhold, any additional monies left are shared equally between the employer and the PPO. If actual claims are greater than expected claims, then the physicians will not receive their withhold but they are not liable beyond that risk.

The Pine Bluff PPO is almost an exclusive provider organization (EPO) in that employees actually enroll once a year if they want the PPO option. Most benefit plans pay a higher percentage of claims incurred through providers in the PPO network. This basically assures almost total utilization of the PPO network physicians for those employees who elect the PPO option. In fact, most employer plans in the Pine Bluff PPO have more than 90% of their employees select the PPO option versus the free choice, indemnified option.

Administratively, the PPO in Pine Bluff has an executive director with a secretary who does the marketing, administration and management for the organization. Additional responsibilities include the education of providers and their staffs as well as the education and enrollment of employees whose employers offer the PPO program. In the Pine Bluff area, there are enough covered lives to produce adequate administrative fees to cover the overhead costs of the PPO. And so this model has worked effectively for all parties over the past six years.

However, in smaller areas of the state this PPO concept could not work because enrollment would not be large enough to support an administrative staff. Therefore, it is the recommendation of Loweth Enterprises, Inc. that the Arkansas Medical Society consider supporting the development of a large number of local PPOs across the state. This could be done through the development of a management company as a wholly owned subsidiary of the Arkansas Medical Society. The objective of the management company would be to support member physicians throughout the state who want to organize local networks to offer preferred health care services to employers, their employees and dependents.

The Arkansas Medical Society management company would accomplish this by helping physicians in an area of the state organize their own PPO. The management company would work with physicians and employers in the state to develop the product best suited



for that area's needs. The management company would develop a fee schedule and get agreement from the local physician network to agree to a reduced schedule which may be adjusted for local health care costs on a zip code basis. Each PPO would have to agree on credentialing, quality assurance and utilization review. Each local PPO provider would contribute \$300 to the management company towards the cost of putting the local PPO together. Note: the \$300 would be returned to the physicians if no local organization is formed within a specified period of time. Local PPOs may or may not have withholds and may or may not have a primary care gatekeeper system.

The Arkansas Medical Society management company would work with local physician groups to develop the PPO in concert with employers in that area. Employers would have the option of taking up to a 50% ownership position in the PPO with appropriate board representation. The Arkansas Medical Society management company will work with the state and local Chambers of Commerce to facilitate the partnership between providers and employers in developing local PPOs.

The Arkansas Medical Society management company will negotiate local hospital contracts and contracts with other local or statewide ancillary health care providers. The Arkansas Medical Society management company will provide complete marketing, administration and management services for each local PPO with their fee to be \$2.00 per employee per month. This fee will come from participating employers as a part of the cost of their employee benefit program. Thus, the local PPO will not have a revenue stream. On the other hand, it will not have any expenses as everything will be done by the Arkansas Medical Society management company.

The Arkansas Medical Society management company will provide all staff and services necessary to operate each local PPO. This will be done through the management company's central office in Little Rock which will have staff assigned to each region of the state so as to provide personal service, including education and enrollment of physicians and employers in each area. The Arkansas Medical Society management company will not be designed to make a considerable profit. Rather, its fees from each enrolled PPO member throughout the state will allow significant economies of scale and thus reduce individual administrative costs. The central management company will be able to handle the needs of a large PPO (perhaps the Little Rock area organization) as well as the needs of a very small area where there may only be 2,000 employees enrolled.

The Arkansas Medical Society management company will make special efforts to work with statewide employers to meet their needs. This can be done by facilitating contracts with a number of PPOs across the state where that employer has local employees. The centralized management company can also facilitate

contracts with some statewide health care providers where opportunities exist to get volume discounted contracts.

Further development of the detailed, operational aspects of the Arkansas Medical Society management company goes beyond the scope of this feasibility study. But conceptually this plan will meet the needs of physicians in all areas of the state and will allow the Arkansas Medical Society to serve all of its members. The development of this company will certainly take capitalization and operational financial support to get underway, but the funding necessary should be within the means of the Arkansas Medical Society.

In addition to the plan outlined above, we continued to follow-up with the joint venture concept. During our last trip to Arkansas a follow-up visit with one of the individuals we had seen earlier, produced a potentially interested partner for the Arkansas Medical Society. We spoke with a major health insurer with both small and large group products. Most recently, on October 13, 1993, we participated in a two-hour conference call with this major insurer. Present were their Senior Vice President of Strategic Planning as well as their Directors of Managed Care and Field Operations. The outcome of this conference was extremely positive. They are very interested in the potential match of their product, marketing, administrative and management capabilities together with the immediate statewide physician network that the Arkansas Medical Society could bring to the table. We believe that contracting with hospitals will not be difficult in the competitive environment existing in Arkansas today.

This insurer committed that they will give serious thought to our discussion. If they are interested, they have the experience and financial capacity to provide all of the management company functions discussed earlier in this report. Additionally, they have an existing block of business and the financial capability to aggressively market this program throughout the state. Most importantly in this joint venture, the insurer could place the PPO on an insured product basis with both large and small employers. This would give us the ability to offer our PPO program to employers with as few as ten employees, thus giving us much greater market penetration than a self-insured product would afford.

Loweth Enterprises, Inc. believes that there is a clear opportunity to develop a series of small PPOs across the state supported by a single management company. Beyond that opportunity, a partnership between the Arkansas Medical Society and a major health insurer could produce much greater capacity and opportunity for the Society and its physicians. The Society should present a plan to build a number of PPOs linked by a statewide management company, and continue to talk with major insurers who may want to help us achieve our objectives.





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# A Strong Political Presence

Lynn Zeno  
Director of Governmental Affairs

In 1987 the Arkansas Medical Society House of Delegates recognized that the future of medicine was no longer to be decided in medical schools and laboratories, but . . . the future of medicine was to be decided in the halls of the State and National Capitols.

**In January of 1988 the Arkansas Medical Society established the Department of Government Affairs.**

The high-visibility effort was launched with the following objectives:

- To provide accurate and timely information and detail on the laws and regulations affecting the practice of medicine.
- To monitor the evolution of legislation and regulation with the objective of pro-actively steering the outcome of these debates to insure the viability of medicine as practiced by Arkansas physicians.
- To draft and present formal regulatory comments and testimony before those appropriate government entities with jurisdiction over issues affecting the practice of medicine.
- To maintain and develop favorable relationships with key elected officials, opinion leaders in the state and national legislatures, the administration, and others influential in setting health care policy.
- To increase participation in the Arkansas Medical Society Political Action Committee (MED-PAC) and take an active role in supporting candidates who are favorable toward medicine and opposing those who are unfavorable.
- Bottom line . . . to pass good laws and regulations that benefit physicians and the patients they serve and to defeat those proposals that are detrimental.

The Department of Governmental Affairs started with a rush in 1988 by successfully challenging, before the State Insurance Department, a proposed 20% rate increase by the state's largest malpractice insurance carrier. In the six years since its inception, the victories orchestrated by the Department of Governmental Affairs have far outweighed the defeats.

Discussing the political successes achieved by the newly defined pro-active Arkansas Medical Society would take a separate volume of *The Journal of the Arkansas Medical Society*, but among our activities of the past several month are the following:

1. The defeat of a proposed provider tax on physician's gross revenues by the Arkansas Legislature.
2. The successful negotiation of a reasonable worker's compensation fee schedule instead of the adoption of the Medicare fee schedule as proposed by the Worker's Compensation Commission.
3. The successful challenge in U.S. Federal Court of the 20% reimbursement cuts in Medicaid by the Department of Human Services and the anticipated approval of newly negotiated reimbursement rates which will insure access for Medicaid patients.
4. The defeat of a bill which would have prohibited you from refusing to see or limiting your number of Medicare patients.
5. The active participation in both the Governor's Health Care Task Force and the Legislative Health Resources Commission.
6. The coordination of meetings (both in Washington and the home districts) between Arkansas physicians and members of the U.S. House and Senate.





7. The coordination, with Congressman Jay Dickey, of a meeting of Arkansas practicing physicians with President and Mrs. Clinton in the White House.

8. The continued, daily monitoring and participation in legislative hearings concerning health care reform and the practice of medicine.

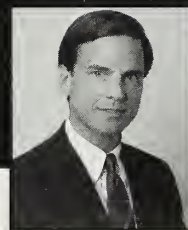
Under the leadership of Charles "Shot" Rodgers, M.D., Chairman of the AMS Governmental Affairs Council; Lynn Zeno, Director of Governmental Affairs; and Laura Harrison, Special Projects Coordinator, the AMS Department of Governmental Affairs continues to accent the importance of membership and grass roots participation by every Arkansas physician in the AR-KANSAS MEDICAL SOCIETY.

(Top) Fourth Congressional District physicians and Lynn Zeno, Director of Governmental Affairs, meet with the President and Mrs. Clinton in the Oval Office

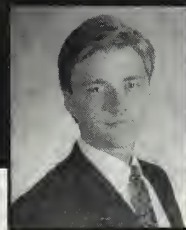
(Above) Attending the Boone County Medical Society Legislative Appreciation Fish Fry were AMS Governmental Affairs Council Chairman Charles "Shot" Rodgers, M.D.; AMS staffers Ken LaMastus and Lynn Zeno and (L to R, front row) former U.S. Rep. John Paul Hammerschmidt, State Senator Jon Fitch, State Representative Bob Watts, State Representative Billy Joe Purdom and State Senator Steve Luef.



# MONEY DIGEST



**James R. Coffield**  
Vice President-Investments



**Todd Smurl**  
Financial Advisor

## Corporate Spotlight

### An Interview with Bryan Hunt

When we were first approached about writing a monthly article for the Arkansas Medical Society, we initially assumed the interest would be in ways for the readership to save on taxes. Maximizing contributions to retirement plans, tax-free bonds, growth stocks, annuities and other insurance products are just a few of the ways to minimize your tax bite.

Even though the interest for the above is there, the Arkansas Medical Society felt that they wanted human interest stories about Arkansas based corporations and what makes them tick in order to present a more diversified and appealing journal to their membership.

For years now, Northwest Arkansas has been a hotbed of corporate activity. From the Tysons to the Waltons there have been many fortunes made deep in the heart of the Ozarks. Recently, Jim Coffield spent some time with the Hunt family in Lowell. The Hunts are the founding family of J.B. Hunt Transportation, which is the largest publicly traded irregular route truck load carrier in the United States.

J.B. Hunt seems to be the driving force behind this progressive company. He is always looking 10 years ahead with a plan, wanting to be on the leading edge of the industry's technology, but more importantly wanting to be on the leading edge of cost containment in relationship to this technology. He always seems to stay one step or more ahead of the competition.

Johnelle Hunt, J.B. Hunt's wife, is the steady hand of this team that handles the details, making sure that everything works. In the early days of hauling rice hulls, she was instrumental in handling the day-to-day operations after a devastating fire destroyed the main building. She ran the entire operation out of a mobile office. She paid the bills, handled employee benefit matters, and was and always has been the glue that holds everything together, allowing Hunt to be the visionary.

She raised the children, daughter Jane and son Bryan (who is now Vice Chairman of J.B. Hunt). She is

still very active today as a board member and secretary/treasurer of the corporation and is very visible and influential in corporate affairs and community affairs statewide.

Bryan's primary responsibilities are in the areas of Operations and Human Resources, including employee benefits, driver turnover and driver safety. We asked Bryan his thoughts on many subjects and areas of corporate concern. Here are some of the highlights of that conversation.

**MD:** Bryan, what does the current debate on health care hold for your company?

**BRYAN:** J.B. Hunt applauds the effort to reform the health care system. We have always been on the leading edge of cost containment while at the same time offering our people premium coverage. Even with our concerted effort to control costs, our health care expenses were still going up at a double digit rate every year. The concern we have is that any reform that does come out of Washington produces a level playing field, which is fair to all employers in our industry and still rewards those who find a way to provide quality care at reduced costs.

**MD:** What about the quality of care in Northwest Arkansas?

**BRYAN:** The quality of care has always been good.

**MD:** And the competitiveness among the hospitals and doctors?

**BRYAN:** Until recently, there did not seem to be a willingness to compete or be a low cost provider. However, since the Clinton's have been pushing the issue, we have noticed a change in the competitive spirit among the hospitals and doctors in our area. They



are much more receptive to the concept of managed care - PPOs, Point of Service Plans and HMOs, which we participate in at our other terminal locations throughout the United States.

Actually, Jim, we only have two main concerns. One, that the final plan should be fair and equal to all employers without additional burdens being placed on companies with over 5,000 employees. Secondly, if the government is going to have a larger role in the matters of private industry, they should be responsible and held accountable for their actions.

**MD:** Environmental issues are also on the front burner these days. Specific to your industry, how is the Clean Air (Act) going to affect your business?

**BRYAN:** The Clean Air (Act) is the environmental tax which mandates a change from high sulphur content diesel fuel to low sulphur content diesel fuel to reduce emissions. This has created capacity problems in the industry and in the supply system. Fortunately for J.B. Hunt, we haven't run out of low sulphur fuel since the switch.

This tax has been as high as 12 cents per gallon, and is now running about 8 cents, and should stabilize when the supply problems are worked out at around 4 cents per gallon. Even at the low end of the projections, this equates to around \$5 million per year for us, and \$15 million at the high end. That is serious money! The margins of most trucking and transportation companies are too low to absorb. What does this mean? These costs will be passed on to shippers. You know the rest - shippers pass on costs to manufacturers or distributors, they ultimately pass on to you and me, the consumers, which in the end is inflationary.

**MD:** Employee turnover has always been a big problem in the trucking industry. Is it still a problem, and if so, how is J.B. Hunt dealing with it?

**BRYAN:** That is definitely a big concern of ours. I just got back from the American Transportation Association's annual meeting, and probably the biggest topic of discussion was the lack of qualified drivers and applicants. In 1992, we had driver turnover of 105%. We have reduced turnover to 80% so far this year, and our goal is to reduce it to 40% by 1995.

**MD:** Sounds ambitious. How do you plan to pull it off?

**BRYAN:** By becoming much more organized and by making a concerted effort to satisfy our people.

That probably sounds simplistic, but what I am talking about is creating working conditions which will enable us to keep people longer. Our alliance with the

railroads is a good example. The railroads will do the long haul jobs while we will handle the picking up and delivering to the rail yards. This will create a lot of local jobs for our driving force. Jobs which will allow them to be at home every night, or at least every other night. We will still have regional jobs which will allow them to be home every weekend, and of course, there will still be a place for the long haul driver, who will be gone for as long as three weeks at a time.

This flexibility will allow us to attract the best drivers in the industry, reward those drivers with the things that are important to them, not necessarily money, and most importantly it will enable us to reduce our turnover. The bottom line is that through planning and careful management, we feel that we should be able to continually increase our earnings, even during times when we can't easily increase our revenue.

**MD:** Bryan, everyone seems to have an opinion on NAFTA. By the time this goes to the readers, Congress will have already voted on the treaty. Go ahead and give us your viewpoint.

**BRYAN:** We are already the largest truckload carrier in Canada. Except for Quebec, which is predominately a French speaking province, you don't have the language and cultural problems that you do in Mexico. In Quebec we have handled that by using drivers who actually live in Quebec.

Mexico, now that is a different situation altogether. When you get outside of the major population centers like Mexico City, Acapulco, Cancun and Puerto Vallarta, Mexico really becomes very much like a third world country. Fuel stops are few and far between, nobody speaks English and the cultural differences are extreme. There is almost a total lack of infrastructure, the airports are bad, the roads are ravaged, and the water and sewer systems are pitiful. It really is a bad situation that has to improve over time, but we're convinced that it will.

The bottom line for J.B. Hunt is that we want the NAFTA legislation to pass. American exports to Mexico have tripled over the last five years to over \$42 billion, which is creating jobs for our country. There is a very vocal minority in this country that doesn't understand globalization. J.B. Hunt has to compete globally now, and we are doing so in Mexico through an alliance with Transportacion Maritima Mexicana. In Canada we don't need an alliance, we just run our own trucks.

**MD:** Past NAFTA, what is next for (J.B.) Hunt, and in what form and venue?

**BRYAN:** Well, rail transportation is already a reality with us. We see the International Steamship business as being the next big growth area for our business. The

U.S.A. only has one steamship line - the rest are foreign.

**MD:** Do you plan on merging with or acquiring a steamship company?

**BRYAN:** We'll let them move the freight on the waterways. Our interest is in providing the land transportation. We see our next big markets as being in Europe and Asia. You'll see us announce global partnerships similar to our arrangement in Mexico.

**MD:** What about Australia?

**BRYAN:** We've looked at it seriously, but it's too far away and there just isn't enough import/export business. There is not enough opportunity to justify the risk to our stockholders. At this point, we feel Europe and Asia are much more profitable. Even the Eastern-Bloc countries of Europe could prove to be lucrative at some point in the future if and when they make a successful conversion to capitalism.

**MD:** Bryan, one last thing before we stop, I've noticed that your dad's vision of the company is rubbing off on you and your management team. He's got to be very pleased with this team concept going forward.

**BRYAN:** I think he is very pleased that our team is sharing in his corporate vision, and I believe it started in 1990 with our corporate mission statement - we want to dominate transportation and not just trucking. We are a total transportation company now and will be a major global transportation company in the future. It's a very exciting time for us and our stockholders.

I would also like to thank you for taking the time out of your day to do this for the Arkansas Medical Society. We are very proud to be the first public Arkansas company featured in your new "Money Digest" column.

**MD:** Speaking of your dad, is he showing any signs of slowing down since the whole J.B. Hunt team has picked up on his vision for the company?

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Average Daily Volume:	137,920
1992 Revenues:	900 million +
Employees:	10,000 +

**BRYAN:** Jim, he is never going to slow down. He loves this business, and in a lot of ways is no different than he was 20 years ago.

**MD:** Bryan, this has been a great interview. Thank you for your time.

Special thanks to the Hunt family, Steve Palmer - Executive Vice President of Human Resources/Risk Management at J.B. Hunt, and Fred Hunt and Captain "Mac" McInnis for their help on this article.

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*Jim Coffield and Todd Smurl are Financial Advisors with the Little Rock office of Prudential Securities. Any opinions expressed in this article are those of the authors, and not those of Prudential Securities.*

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# The Treatment of Pain in Children with Cancer

Raeford E. Brown, Jr., M.D.\*

Michael L. Schmitz, M.D.\*\*

Pam Andelman, RNP, BSN\*\*\*

## INTRODUCTION

Children with cancer have pain associated with the primary disease process, its diagnosis, and treatment. Fear of pain and painful procedures affects the quality of life of patients. Pain associated with cancer can be safely and effectively treated.

## CASE REPORT

**Case 1** - The patient is a three-year-old female with a history of acute lymphocytic leukemia. Despite routine induction and maintenance chemotherapy, she suffered a relapse and required reinduction. Numerous bone marrow biopsies and lumbar punctures were required to monitor her course of therapy. Conscious sedation with midazolam and fentanyl was utilized during these procedures to reduce anxiety and eliminate pain. The guidelines of the American Academy of Pediatrics on Sedation for Painful Procedures were followed with strict attention to patient monitoring. The patient tolerated these procedures well.

**Case 2** - The patient is a fifteen year old with osteogenic sarcoma. Despite aggressive chemotherapy and surgical intervention, the malignancy was found to be widely metastatic. The parents desired terminal home care, but expressed fear of the child's pain. The patient was stabilized in the hospital using a Patient Controlled Analgesia (PCA) device. He was sent home and man-

aged as an outpatient by his oncologists and the Pain Management Service utilizing the PCA. Largely because of this management, he was able to participate in routine activities until the last day of his life.

## DISCUSSION

Pain is common in patients with cancer. In fact, up to 40% of patients with cancer suffer from pain and as many as 80% of patients with advanced disease experience moderate to severe pain. The World Health Organization (WHO) feels that there may be 25 million people throughout the world who die each year without adequate pain control. It has been thought that fewer children with cancer suffer from pain when compared to their adult counterparts. However, recent surveys of the prevalence of pain in childhood cancer patients at the National Cancer Institute reveal that as many as 26% of outpatients and 54% of inpatients suffer from significant pain. Other surveys in children and young adults suggest that nearly 80% of respondents suffer pain with prior to or subsequent to the diagnosis of their cancer. There are numerous causes of pain in patients with cancer. Invasion of soft tissue and bone is perhaps the most common cause. Because of the prevalence of hematologic disorders, such as leukemia, in children invasion of bone is not often encountered. Invasion of neural structures, the side effects of chemotherapy, the effects of surgery, and painful diagnostic procedures all make for acute and/or unremitting chronic pain in children. Clinicians may or may not be aware of this serious issue in their interactions with patients. Given the large number of patients affected, health care providers must consider pain in their ongoing evaluation of the pediatric patient with cancer. The assessment of pain in children with cancer may be difficult. The individual developmental level of the child plays an important role in the child's behavior and the tools that may be used to assess pain. Numer-

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\*\*\* Pamela D. Andelman is Nurse Specialist, Pain Management Service, Arkansas Children's Hospital.



ous pain scales have been validated for all developmental levels down to and including infants. However, the assessment and therefore the adequate treatment of pain in nonverbal children remains problematic.

Repeated bone marrow aspirations, lumbar punctures and bone marrow biopsies continue to characterize the experience of children suffering from cancer. The experience of the National Cancer Institute concerning these procedures is instructive. In their series, 78% of children receiving bone marrow aspirations and 61% of those receiving lumbar punctures reported moderate to severe pain. In this survey, pain ratings were obtained using a validated visual analog scale and included patients age 2 to 19 years. Indeed, the pain of procedures is significant. Children undoubtedly find it difficult to understand that pain accompanies procedures which are performed in their best interest in order to attain accurate diagnoses and optimal treatment. Recent articles demonstrate the safety and efficacy of intravenous agents such as fentanyl and midazolam for sedation in children having painful oncological procedures. Recent statements by the American Academy of Pediatrics encourage the use of conscious sedation for painful procedures and provide standards for monitoring such care.

The pharmacological treatment of invasive cancer pain need not be complex. However, certain tenets must be noted.

1. The patient must be believed. The clinician must keep in mind the 1979 definition of pain published by the International Association for The Study of Pain:

"Pain is an unpleasant sensory and emotional experience associated with actual or potential damage or described in terms of such damage. Pain is always subjective. Each individual learns the application of the word for experiences relating to injury in early life. It is unquestionably a sensation of a part or parts of the body, but it is always unpleasant and therefore an emotional experience."

Therefore, pain is what the patient says it is and the goals of the clinician should be to provide comfort, relief, dissolution of fear, and reduction in anxiety for this unpleasant experience.

2. The longer pain is endured the greater its intensity - efforts on the part of clinicians to increase the length of time that patients are not treated for pain does not improve the patient's tolerance of pain.

3. In terms of pharmacological management, there are two "golden" rules:

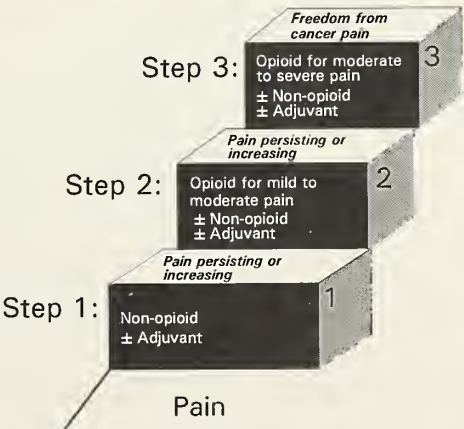
- i) All pain management must be empirical and individualized, and
- ii) The dose that works is the dose that works.

In children as in adults, analgesic therapy which follows the WHO cancer pain relief guidelines continues to be the mainstay of cancer pain management (Figure 1). These guidelines highlight therapy which is widely available and is successful in an overwhelming number of cases. In fact, surveys indicate that analgesic therapy following WHO guidelines is successful in nearly 70% of patients suffering from cancer pain. These guidelines, the so called WHO analgesic ladder, suggest the use of non-opioid compounds such as acetaminophen or nonsteroidal anti-inflammatory agents for mild pain early in the disease. Subsequently, adjuvant agents may be added as co-analgesics when pain becomes somewhat more severe. These adjuvant agents may include antibiotics, steroid compounds, tricyclic antidepressants or nonpharmacological modalities, such as transcutaneous nerve stimulators. For pain that is persistent or increasing, mild opioids may be added to non-opioid compounds with or without adjuvants. Codeine has been widely used for this purpose in children and is safe and effective when used in combinations with nonsteroidal anti-inflammatory drugs, acetaminophen, or other adjuvants. Codeine also has a lower incidence of the undesirable side effects of narcotic compounds. Doses greater than 65-100 mg orally may provide only marginal increases in analgesia while producing substantial side effects. Hydrocodone is commercially available and may be used in fixed dose combinations with acetaminophen. The use of this drug, however, is limited by its fixed dose combination.

For patients with persistent or increasing pain, mild opioids should be replaced by more potent and effective compounds such as morphine, hydromorphone and methadone. Although methadone is widely available and cheap, this drug has been replaced by the rou-

**WHO Analgesic Ladder \***

Figure 1



\*Cancer Pain Relief and Palliative Care. Geneva, World Health Organization in press, 1990-91.

tine use of oral or intravenous morphine as the treatment of choice for patients with severe cancer pain. Control release morphine tablets are available in which the rate of drug release from a matrix of aliphatic alcohols and alkyl cellulose is controlled and constant. For this reason, morphine may be administered every 12 hours and provide an adequate duration of action. MS Contin® is one such sustained release form of morphine currently available. This drug is marketed in 30, 60 and 100 mg size tablets and is being studied in tablets of 15 and 200 mg. Because of the large chronic doses required to meet the needs of children with pain, there is really no established maximum safe dose of morphine and most other mu agonist opioids. Treatment of the side effects of oral and parenteral opioid analgesics is accomplished with relative ease so that patients may obtain analgesia with minimal discomfort from side effects. Oral morphine in quantities of grams per 24 hours has been administered without untoward side effects which lends credence to the observation that opioid analgesics do not reach a ceiling effect.

Other forms of pain in children with cancer may not be adequately relieved by opioid analgesics. The invasion of neural structures by solid tumors or the neuropathic injury caused by certain therapeutic agents is often identified as problematic for pain control. Patients may describe lancinating pains passing through their extremities or "pins and needles" in various areas of their body. Anticonvulsant agents such as

phenytoin and carbamazepine have been demonstrated to be effective in the reduction of these types of pain. Patients on carbamazepine, however, must be monitored for neutropenia and thrombocytopenia as these are signs of toxicity with this drug. Baseline and periodic screening of hepatic and renal function is also recommended.

It is often said of the patient with pain who has cancer, think cancer first. Treatment of the primary malignant process with surgical intervention, radiation, chemotherapy or steroid compounds may be extremely effective in reducing levels of pain in all patients, including children. Those patients who do not respond to medical or surgical intervention should be provided with relief. The treatment of pain in children with cancer can be safely accomplished based on simple scientific principles. Fears concerning the dangers of narcotics, including addiction, or of other drugs used for pain relief are often unfounded and should not be determining factors in our treatment of patients.

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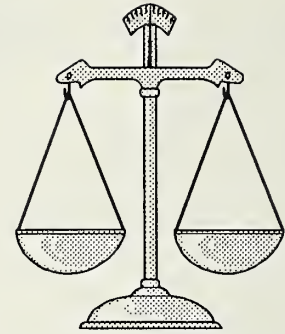
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# Utilization Review Puts Doctors on a Tightrope

David L. Ivers, J.D.\*



If they haven't already, many physicians at some point are going to find themselves in a catch-22 similar to the following:

Howard Wilson, Jr. was admitted to College Hospital in Los Angeles while suffering from major depression, drug dependency and anorexia. He had lost twenty pounds in two months. Dr. Warren Taff was his treating physician. Dr. Taff determined that Wilson needed three to four weeks of in-patient care at the hospital. But after only ten days, the patient's insurance company informed Dr. Taff that it would not pay for any further hospital care because its utilization reviewer had determined that it was not justified. Dr. Taff told the patient the bad news and explained to his family that they must bear the cost of any further hospitalization. The family did not have the money, so Dr. Taff discharged the patient. Three weeks later the young man committed suicide.

Who, if anyone, is legally liable in these situations? The treating physician? The insurance company? The physician conducting the utilization review? The answer at this time is not clear since it is an issue with which the courts have only recently begun to grapple. The only state to address the issue at the appellate court level is California. However, as managed-care becomes a way of life physicians everywhere can expect to find themselves in the same "rock-and-a-hard place" quandary that Dr. Taff faced.

In the case described above, *Wilson v. Blue Cross of Southern California*,<sup>1</sup> the patient's family sued Blue Cross and Blue Shield of Alabama (who covered Wilson), Blue Cross of Southern California (to whom Blue Cross and Blue Shield of Alabama had delegated the administration of claims), Western Medical Review (who had contracted with Blue Cross of Southern Cali-

fornia to perform utilization review), and the Western Medical physician reviewer who handled Wilson's claim.

Doctor Taff, whom the family did not sue, was prepared to testify that there was a "reasonable medical probability" that Wilson would have been alive if his hospital stay had not been prematurely terminated. The Defendants argued that the sole liability rests with the treating physician, i.e. Doctor Taff. The trial court agreed and granted summary judgment in favor of the defendants, but the appellate court reversed. The appeals court found that the insurance companies and utilization reviewers could be held liable as well if their conduct was a "substantial factor" in bringing about the injury or death. The court noted that this was a possibility since the evidence showed that "the sole reason for the discharge... was that the decedent had no insurance or money to pay for any further inpatient benefits." The court found that the evidence showed the defendants were potentially negligent in denying Wilson's claim, and ordered the lower court to allow the case to proceed to trial. The parties later settled out of court.

The dilemma that the *Wilson* case represents is caused by the inevitable tension between the need to ensure quality medical care for the individual and society's need to control health care costs. Under traditional fee-for-service insurance agreements, doctors were accustomed to putting the patients' needs above cost concerns since the physician received payment for each and every service provided. But all that has changed with managed-care.

Managed-care, of course, can take a variety of forms, the most common of which is the health maintenance organization. But whatever form it takes, the managed-care company normally relies heavily on utilization review. Utilization review is the process by which health care services are examined to ensure that the services provided are both necessary and cost efficient. (Medi-

\* Mr. Ivers is an associate with Mitchell, Blackstock, Simmons & Barnes in Little Rock, general counsel for the Arkansas Medical Society.



care peer review organizations also conduct utilization review, but are currently immune from liability for negligent review decisions.) Utilization review can be either retrospective or prospective. In retrospective utilization review, the claim is not reviewed until after the care has already been provided. While this may lead to disputes over who will pay the bill, it does not have a great impact on whether the patient receives care. The trend, however, is towards prospective utilization review, in which the patient's claim comes before the care is to be given. Insurance coverage is denied if the utilization review criteria are not satisfied and, for most patients, denial of coverage means denial of treatment altogether.

Utilization review is normally a two-step process. First, a nurse or other nonphysician reviewer applies predetermined criteria to the claim presented by the attending physician. If the proposed treatment plan does not fit within the criteria, then the matter is referred to a utilization review physician consultant, who makes a final determination, normally in consultation with the attending physician. An effective UR program is supposed to evaluate the quality as well as the cost of medical care. However, along with the normal pressures to control costs, many managed-care plans have now given physicians added incentives to err on the side of less care instead of more. For instance, many managed-care plans have a capitation arrangement in which the physician is given a set amount of money per patient no matter how much care is provided, and therefore, the less care the physician provides, the more money he or she makes. So what happens when this delicate balance is improperly tilted in favor of cost containment and tragedy results?

While the family in the Wilson case did not sue the treating physician, that does not mean the treating physician cannot be held liable. Indeed, in a previous California case,<sup>2</sup> the court warned that physicians must follow the appeal process or whatever else is necessary to try to obtain coverage for the patient. In that case, Lois J. Wickline was being treated by her family physician, Dr. Stanley Daniels, for problems with her back and legs. When she failed to respond to physical therapy, Dr. Daniels had her admitted to Van Nuys Community Hospital and brought in another physician, Dr. Gerald Polonsky, a specialist in peripheral vascular surgery, to do a consultation examination. Dr. Polonsky diagnosed her condition as arteriosclerosis obliterans with occlusion of the abdominal aorta, more generally known as Leriche's Syndrome. In Wickline's case her disease was so far advanced that Dr. Polonsky concluded that it was necessary to remove a part of her artery and insert a Teflon graft in its place. Medicaid authorized the surgical procedure and ten days of hospitalization for that treatment. Wickline's recovery was "stormy." Eventually she had to be returned to the operating room for a

lumbar sympathectomy. In all, she had three surgeries with Dr. Polonsky being assisted by a Dr. Kovner.

On the date she was to be discharged, Dr. Polonsky concluded that it was medically necessary that she remain in the hospital for an additional eight days. However, Medicaid's utilization review program rejected the request. Medicaid's UR program used consulting physicians selected at random. Dr. William S. Glassman happened to be called this time. Dr. Glassman rejected the request for an eight-day extension, and instead, authorized only an additional four days. Soon after Mrs. Wickline was discharged, complications developed, requiring the amputation of her right leg.

Mrs. Wickline sued the State of California, which operated the Medicaid program. However, the court found Medicaid was not liable for various reasons, one of which was the fact that all three of Mrs. Wickline's doctors were aware that they could attempt to obtain a further extension of her hospital stay but none of them did so. The court warned:

[T]he physician who complies without protest with a limitation imposed by a third-party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour.

So what does all this mean for physicians? First of all, it appears Arkansas has yet to address these issues, but as managed-care becomes more widespread, they are sure to arise. However, the fears may be somewhat exaggerated. Although not addressed by the California courts, a number of commentators and at least one court<sup>3</sup> have concluded that the federal Employment Retirement Security Act (ERISA) prohibits these claims in most cases. The issue is not settled, however, and it is likely to take more lawsuits or action from Congress before physicians know their true liability exposure.

In the meantime, treating physicians should be careful to always adhere to accepted medical standards in spite of the cost containment pressures. When their recommendations are denied by the utilization reviewer, they should do whatever is necessary to challenge the decision. As the court in *Wickline* stated: "While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment."

As for physicians in the role of utilization reviewer, they must also be careful to base all decisions concerning necessary medical care on accepted medical standards. They should conduct a comprehensive investigation of all material facts or, at least, as one court has stated, they should make "reasonable efforts to obtain all medial records relevant to the hospitalization," in-



cluding a call to the attending physician's office if necessary.<sup>4</sup> Utilization reviewers should also make sure that all of their methodology and procedures are proper. Defects leading to liability could include poor program design, incompetent management and monitoring, inadequate documentation, bad faith, and poor judgment in rendering utilization review decisions. Professional utilization review standards developed by various organizations encourage voluntary compliance with specific criteria, e.g., verbal notice of determinations provided within two working days; a reasonable attempt to contact the attending physician before issuing a denial determination; and the right, on appeal, for the claimant to have a review by a different medical consultant of the appropriate specialty.<sup>5</sup> In addition, a voluntary certification program is currently being developed by UR professionals. The Arkansas General Assembly also has instructed the state Board of Health and the state Insurance Commissioner to develop regulations governing utilization review.<sup>6</sup> Perhaps most importantly, the utilization reviewer should remember that the attending physician is in the best position to evaluate whether utilization constraints are appropriate in a given case.<sup>7</sup>

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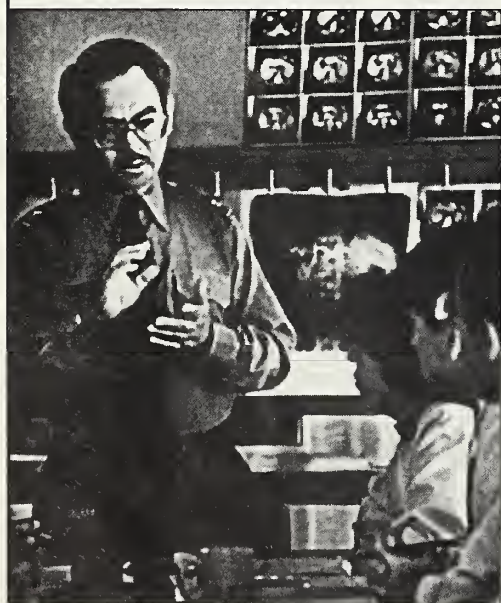
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# AMS STAFF SPOTLIGHT

*The various services supplied by the Arkansas Medical Society are best illustrated by introducing each staff member and describing the specific job they do for the Medical Society. Each member of the AMS management and staff and their job duties are unique. They are dedicated to providing Arkansas Medical Society members with the best information and services available. It should be noted that the persons listed in this article have over 100 years of combined work experience. That experience can only bode well for the future of the Society and its members.*

## **Ken LaMastus** **Executive Vice President**

Ken is a Certified Association Executive and has been with the Medical Society for sixteen years. He holds both Bachelor's and Master's degrees in Business. Prior to coming to AMS, he trained as a lab technician (AMT), taught economics and finance at the college level, and was a hospital administrator in eastern Arkansas.

In addition to his duties as executive vice president, Ken has served on several boards and commissions and is Past-President of the Arkansas Society of Association Executives.



**KEN LAMASTUS**

## **David Wroten** **Assistant Executive Vice President**

David began his duties with AMS in 1983 as the Professional Relations Coordinator. He had just completed his education at Arkansas State University where he received a Bachelor's degree in Finance and Master's in Business Administration (M.B.A.)

David's current responsibilities at AMS include membership, education, publications, PAC and the CME accreditation program. His duties include working with the medical students, resident and young physicians, and he was largely responsible for the creation of the medical students and resident physician component societies. David helps physicians with Medicare and Medicaid problems and answers questions about medical records and practice management. He works closely with the other executive staff members applying a team approach to problem solving and the planning and implementation of AMS activities and services.



**DAVID WROTEN**



## **Kay Waldo**

### **Director of Administrative Services**

Kay joined the AMS staff in July 1991. Kay is responsible for the daily office operations of the Society, as well as personnel, finance and meeting planning. She is the coordinator for the Arkansas Medical Society annual convention, House of Delegates meeting and council meetings. Kay also plans and assists with educational seminars and provides administrative support for the Continuing Medical Education Accreditation program.

Kay previously worked for a local bank for nineteen years, with her last position being Vice President and Personnel Director. She has completed courses offered through the American Institute of Banking and is a graduate of the ABA Basic Personnel School and the ABA Human Resources Graduate School.



**KAY WALDO**

## **Z. Lynn Zeno**

### **Director of Governmental Affairs**

Lynn Zeno received his Bachelor's and Master's degrees from Henderson State University. He became the first full-time AMS Director of Governmental Affairs in December of 1987 after spending 10 years as an insurance industry lobbyist.

As Director of Governmental Affairs, Lynn is responsible for legislative and regulatory activities pertaining to state and national issues. He established a political education program for grassroots participation in legislative affairs for AMS and AMS Auxiliary members. He is staff liaison for the AMS Political Action and Governmental Affairs Committees.

He is a past president of the Arkansas Society of Association Executives and the Arkansas Society of Professional Lobbyists. He serves on numerous governmental advisory committees and is a faculty member for the Arkansas Institute for Continuing Legal Education. Lynn serves as one of ten members, nationwide, to the American Medical Association's Legislative Advisory Committee.



**LYNN ZENO**

## **Nadine Gentry**

### **Administrative Assistant/Specialty Secretary**

Nadine is administrative assistant to the Executive Vice President and the Director of Administrative Services.

She maintains the Arkansas Medical Society Political Action Committee (MED-PAC) membership files and the House of Delegates roster. She assists with various committees (including the Executive Committee and Council) and meetings (annual session, fall meeting and Society sponsored seminars).

Nadine provides services for the Arkansas Medical Society Alliance, Arkansas Chapter, American College of Surgeons, Arkansas Orthopaedic Society, Arkansas Society of Internal Medicine, Arkansas Hand Club



**NADINE GENTRY**

and Arkansas Society of Plastic and Reconstructive Surgeons.

She is responsible for the Arkansas Medical Society Office Manual and Officers' Manual which is a composite of AMS committees, officers, county, Alliance and specialty society officers, delegates, constitutions and bylaws, and a resource guide to health care boards, foundations and health related service organizations.

Nadine has been with the Arkansas Medical Society since 1984. Prior to her employment with the Arkansas Medical Society, she worked at the Arkansas Department of Health for nine years.

### **Laura Harrison** **Special Projects Coordinator**

In May 1987, Laura joined AMS as assistant to Lynn Zeno, Director of Governmental Affairs. She coordinates the "Day at the Capitol" program, other legislative events and helps track legislation. Laura helps coordinate the Society's Annual Session, as well as produce various brochures and certificates for other events. She acts as staff liaison to the AMS Committee on AIDS and coordinates the annual AIDS seminar sponsored by the Society. Laura also works with the AMS Physician Placement Service, AMS Resident and Medical Student Sections.

Prior to joining the Society staff, Laura worked as a media assistant at a local advertising agency where she handled marketing and media proposals for local, regional and national clients. In 1985, Laura graduated from the University of Arkansas at Fayetteville with a Bachelor's degree in Journalism specializing in Advertising/Public Relations.

### **Judy Hicks** **Receptionist/Membership Assistant**

Judy joined the AMS in March of 1987. Her responsibilities include membership, membership services and recruitment. This includes continuously tracking and updating information for all AMS members, non-members and Alliance members.

She provides information for the annual membership directory, works with the county medical societies and assists the bookkeeper with various projects, as well as handling AMS telephone calls and other miscellaneous tasks.

### **LeAnne Rogers** **Administrative Assistant**

LeAnne joined the Arkansas Medical Society staff in February 1993 as Administrative Assistant to David Wroten. She assists David with projects pertaining to Medicare, Medicaid and practice management. Her duties as Assistant to the Plan Administrator for AMS insurance programs include customer service and data



**LAURA HARRISON**



**JUDY HICKS**



**LEANNE ROGERS**



processing.

LeAnne graduated from the University of Arkansas in Fayetteville with a B.A. degree in Psychology. She has eleven years of medical office experience and recently completed a nine month course in Medical Practice Management.

**Cindy Sawrie**  
**Journal Managing Editor**

Cindy is responsible for all aspects of *The Journal of the Arkansas Medical Society*. Her duties include production, advertising and circulation. In addition to *The Journal*, she produces the annual membership directory and various other printed material.

Cindy graduated from the University of Arkansas at Fayetteville in 1988, with a B.A. degree in Journalism specializing in magazine production and a minor in Art. She joined the Medical Society in January 1993 after working in retail advertising for over four years, most recently at Dillard's Divisional Offices in Little Rock.

**Alanna Scheffer**  
**Plan Administrator, AMS Benefits**

Alanna began working for AMS Benefits in February 1992. She is the administrator of the Arkansas Medical Society Health Benefit Plan.

Before joining the AMS staff, Alanna worked for a local health and accident insurance company for ten years where her last position held was office manager in charge of claims and underwriting.

Alanna has completed courses offered through the Life Office Management Association with specialization in selection of risk.

**Teresa Sidebottom**  
**Bookkeeper/Membership Director**

Teresa joined the AMS staff in March of 1986. As the AMS bookkeeper, Teresa is responsible for all accounting which includes payroll, accounts payable and receivable, reports and the budget. In addition, she also is responsible for Arkansas Health Care Access Foundation, Medical Education Foundation For Arkansas and MED-PAC.

Teresa's other major area of responsibility is membership. This includes billing and collection of county, AMS and AMA membership dues, and keeping track of dues exempt status with the Arkansas Medical Society. She also organizes the recruitment efforts for perspective AMS members.



CINDY SAWRIE



ALANNA SCHEFFER



TERESA SIDEBOTTOM



# Outdoor MD

Information provided by  
the Arkansas Game & Fish Commission

## THOSE MERCURY ADVISORIES ON FISH: NECESSARY BUT PERPLEXING

A new fish consumption advisory issued by the Arkansas Department of Health added three areas in south Arkansas plus one in north Arkansas to the list of waters where mercury has been found in predator fish, primarily largemouth bass.

Members of the Arkansas Mercury Contamination Task Force suspect mercury is coming from both natural (ground) and air sources.

Mike Armstrong, assistant chief of fisheries for the Arkansas Game and Fish commission, said there are some differences in the newest advisory from the Health Department from previous advisories over the past year.

Armstrong said, "The Health Department specifically targets the advisory towards 'high risk groups' defined as people who routinely consume more than two meals a month from the advisory waters as well as children under seven years of age and women who are pregnant or plan to become pregnant.

"Occasional consumers are not considered at risk. Children and pregnant women are considered high risk due to EPA (U.S. Environmental Protection Agency) data strongly suggesting the amount of mercury needed to cause problems is five times less than for a normal adult."

The federal guidelines call for limited consumption of fish where tests have found mercury levels over one part per million. Health officials have said the guidelines are conservative; adverse effects for people eating mercury-laden fish have been found only where levels are much higher than the red-flag one part per million.

The newest advisory is for largemouth bass over 16 inches in the South Fork of the Little Red River in Van Buren County, Lake Nimrod in Perry and Yell counties, Fourche La Fave River from Nimrod Dam to its junction with the South Fourche River in Perry County and Dorcheat Bayou in southwest Arkansas (Nevada, Miller and Columbia counties).

Armstrong said, "There is no advisory on other popular sport species such as crappie, bream and catfish or on bass less than 16 inches long. On a lake like Nimrod, the catch is mostly crappie, catfish and bass less than 16 inches. Fishermen need to keep a common sense perspective on what is actually covered under the advisory.

"The advisory on the South Fork of the Little Red River is the first mercury advisory outside the Ouachita Mountain drainage area, and this implicates Greers Ferry Lake. But data collected in 1991 indicated levels of mercury well below the federal tolerance level. Additional collections of fish and tests will be made over the next month on the upper end of Greers Ferry, and hopefully this will substantiate our earlier findings."

Officials of the Mercury Task Force, appointed last January by Governor Jim Guy Tucker, said Arkansas is one of 28 states where health officials have issued warnings about eating fish.

In Arkansas, high-level mercury has been found mostly in largemouth bass. Elevated levels of mercury in flathead catfish and chain pickerel have been found in south Arkansas. In most areas where mercury has been found, non-predator fish such as bream, buffalo, channel catfish and suckers have tested well within the safe-eating category.

Armstrong said, "Finding the source of the mercury is important, but just as important to solving our problem is controlling the conditions that allow mercury to enter the biotic food chain. Any natural or man-made condition that creates slightly acidic conditions in the presence of high amounts of dissolved organic material and low oxygen in water can lead to mercury buildup in fish."

## WORTHEN VISA CARDS BENEFIT WETLANDS, OUTDOOR RECREATION

A VISA card for the Arkansas Game and Fish Foundation has been created by Worthen Bank.

The bank card features the Foundation's logo, and part of its fees go to Arkansas outdoor projects such as wetlands preservation, fish stocking and acquisition of lands for hunting, fishing and wildlife improvement. The Foundation is a non-profit fund-raising auxiliary of the Arkansas Game and Fish Commission.

Steve Smith, director of the Foundation, said the Foundation VISA card through Worthen offers an eight percent interest rate, a low annual fee, a 25-day interest-free period on charges and emergency cash advances.

Applicants for the card don't have to be Worthen customers, he said, and the card are also available to persons already holding another VISA card. For applications or more information, contact any Worthen Bank in Arkansas or call (800) 477-2264.





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118TH ANNUAL SESSION  
APRIL 7-9, 1994

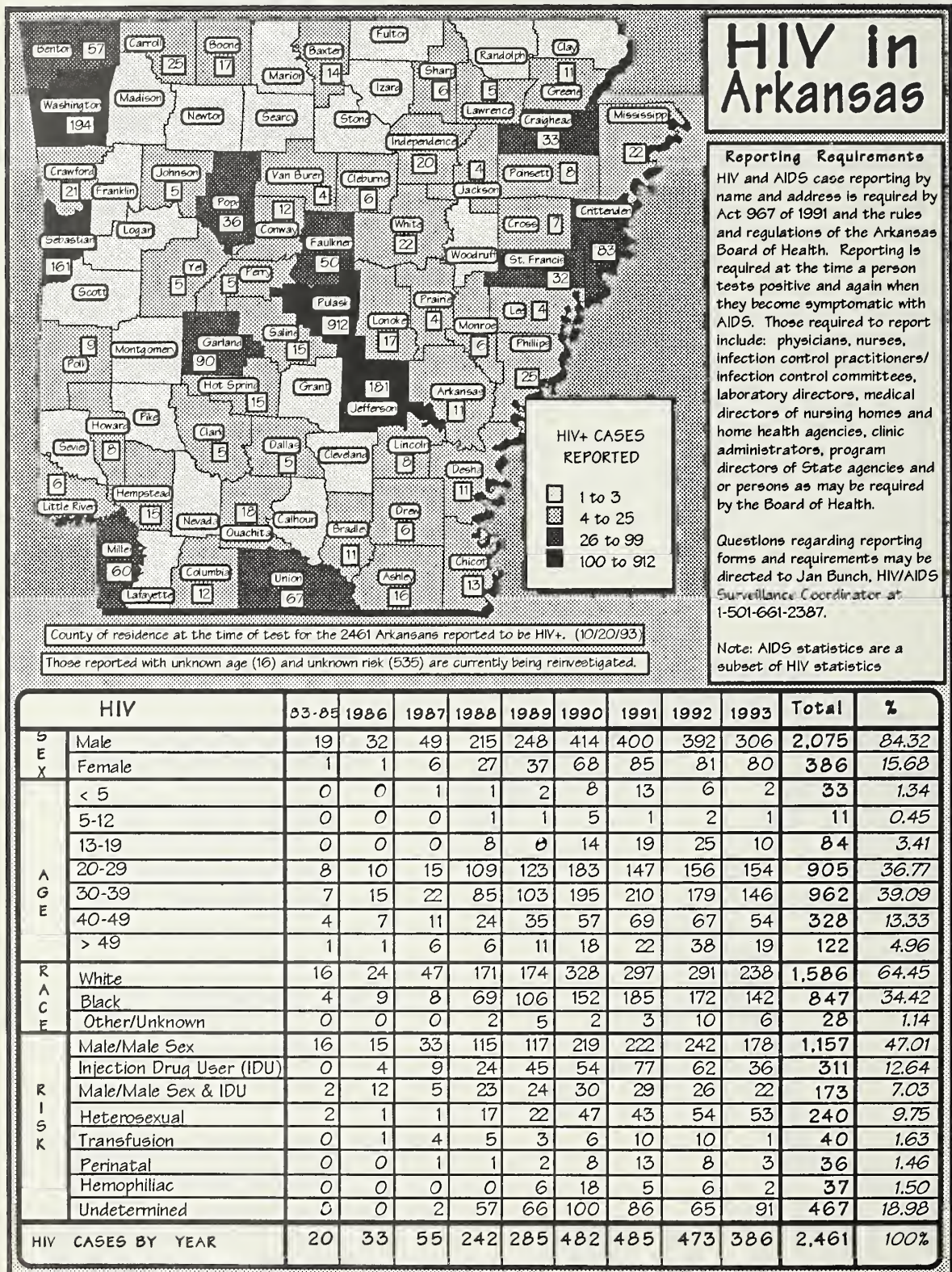
EXCELSIOR HOTEL/STATEHOUSE  
CONVENTION CENTER

LITTLE ROCK, ARKANSAS



# Arkansas HIV/AIDS Report

## 1983-1993

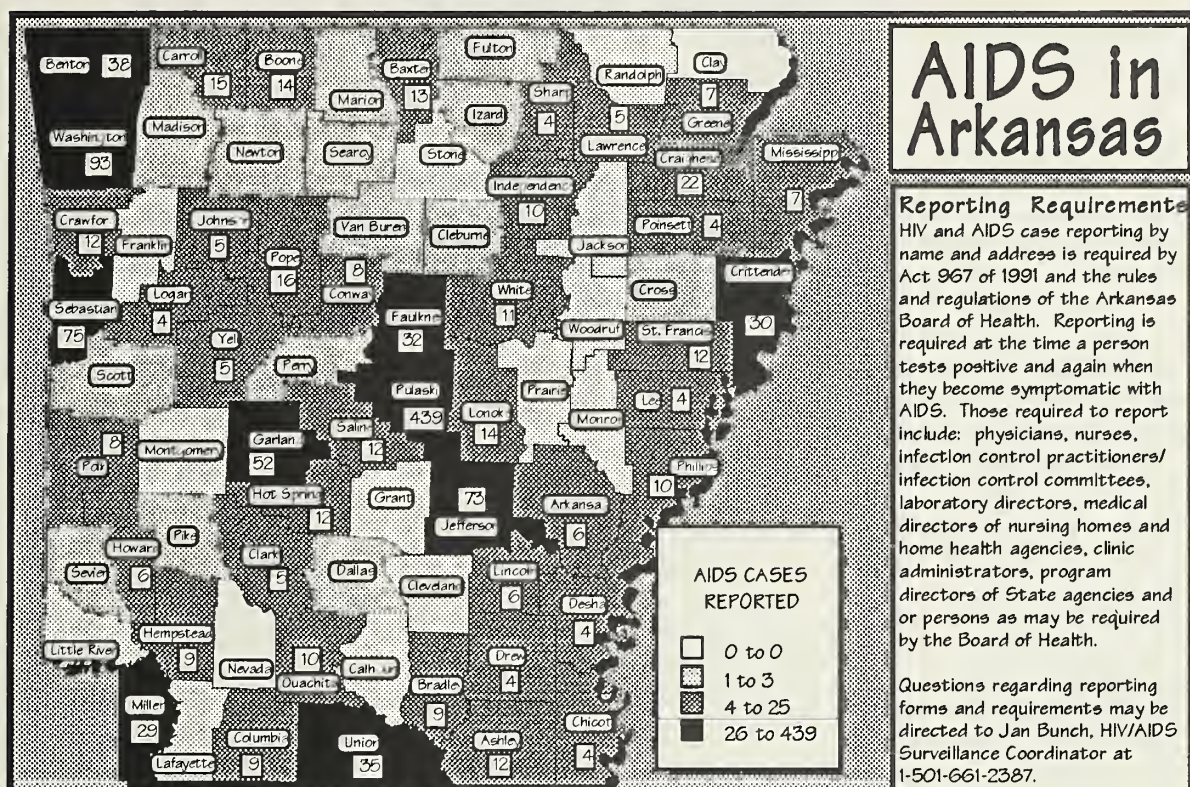


Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1993



Of the 2461 Arkansans reported to be HIV+, 1277 have been diagnosed with AIDS. (10/20/93)

AIDS		83-85	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	293	1,121	87.78
	Female	1	0	4	6	10	20	25	35	55	156	12.22
AGE	< 5	0	0	0	1	1	6	6	3	0	17	1.33
	5-12	0	0	0	1	0	1	1	0	1	4	0.31
	13-19	0	0	0	0	0	4	3	2	4	13	1.02
	20-29	7	9	15	27	24	55	57	81	95	370	28.97
	30-39	3	13	23	36	41	78	80	128	158	560	43.85
	40-49	1	6	8	10	7	35	41	52	67	227	17.78
	> 49	1	0	4	8	7	11	13	19	23	86	6.73
RACE	White	9	22	43	61	58	141	134	206	241	916	71.73
	Black	3	6	7	20	21	47	66	75	103	347	27.17
	Other/Unknown	0	0	0	2	1	2	1	4	4	14	1.10
RISK	Male/Male Sex	7	17	31	59	50	120	120	179	189	772	60.45
	Injection Drug User (IDU)	0	2	10	4	11	18	29	43	51	168	13.16
	Male/Male Sex & IDU	3	9	4	6	6	18	17	19	22	104	8.14
	Heterosexual	2	0	2	3	6	10	9	25	36	93	7.28
	Transfusion	0	0	2	7	3	7	11	3	2	35	2.74
	Perinatal	0	0	0	1	1	6	6	3	1	18	1.41
	Hemophiliac	0	0	0	1	1	5	5	4	5	21	1.64
	Undetermined	0	0	1	2	2	6	4	9	42	66	5.17
AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	348	1,277	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas Health Care Access Foundation

On August 30, 1993, fifty year old Wanda placed a telephone call that may have saved her life. She had been suffering with post menopausal vaginal bleeding for two months and had not been unable to obtain medical care. With an income of only \$425 per month and no health insurance, she could not afford to pay for the initial office visit.

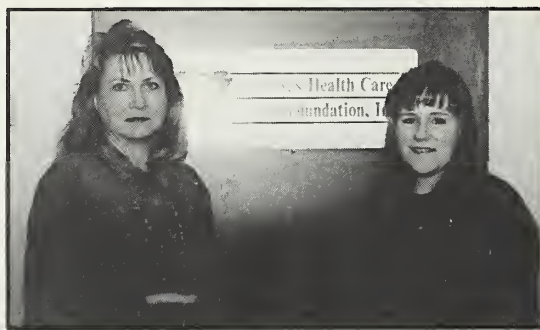
Only a few days before, Wanda had visited her local Department of Human Services Medicaid office in hopes of qualifying for Medicaid assistance. Not being eligible for Medicaid, she completed an application for the Arkansas Health Care Access Foundation, Inc., (AHCAF). That approved application would enable her to be referred to a physician in her area, who would donate the office visit to her.

When Wanda dialed the toll-free number to the Arkansas Health Care Access Foundation, Inc. and explained her symptoms, she was immediately referred to a local volunteer gynecologist, who saw her the next day. Upon the doctor's recommendation, she was referred to a local hospital for diagnostic testing. The diagnosis was cervical cancer. With the cooperation of the physician and the hospital, appropriate medical care was initiated.

Six years ago, the Arkansas Medical Society House of Delegates saw the need for an organized state wide plan to help low income uninsured Arkansans receive medical care. With support from its membership and several prominent Arkansas Legislators, the Arkansas Medical Society began the task of forming an organized network of Arkansas physicians, known as "Arkansas Physicians Care".

In September 1989, with 650 volunteer physicians, the Arkansas Health Care Access Foundation, Inc. began. Now in its fifth year, the program has grown to a membership of over 1,600 volunteers, including dentists, pharmacies, hospitals, home health agencies, pharmaceutical manufacturers, the Arkansas Department of Health and the Arkansas Department of Human Services.

The Arkansas Health Care Access Foundation, Inc. is the largest organized volunteer medical group making available to greatest variety of donated medical services in the state. In a recent study, it was determined that the Foundation provided an estimated \$615,000.00 in donated medical care to its recipients. Due to this unique and generous effort by Arkansas volunteers, a number of other states have requested consultation and information to enable them to pursue



similar endeavors.

The AHCAF, in conjunction with the Arkansas Medical Society, continues to remain committed by exploring new and innovative ways of increasing access to health care for the indigent and less fortunate in Arkansas. An example of this commitment by the Foundation and its Board of Directors involves the successful recruitment of three major pharmaceutical manufacturers.

Because of the efficient manner in which the AHCAF applicant records were maintained, the pharmaceutical manufacturers readily accepted the idea of providing free medications to AHCAF clients. Support from all sectors of the health care community is one of the keys to making this a successful program. Our family of volunteers continues to expand. And as our list of health professionals grows, so too does our commitment and our resolve to build upon it in the future.

We all recognize the unfortunate situations that many must endure, but few exhibit the determination in implementing a solution. Since 1989, we have reached thousands of people, ending much suffering, and led by example in the quest for broader access to medical care. Through continued, cooperative efforts such as AHCAF, we will reach our goal and help ensure the health and welfare of all Arkansans.

## EXECUTIVE COMMITTEE

Harold Hedges, M.D.	President
Joe B. Colclasure, M.D.	Vice-President
Rev. Donn L. Walters	Secretary/Treasurer
Leif Lorenz, DDS	Dental Representative
Jim Teeter	Hospital Representative
J. Thomas Tapp	Pharmacy Representative

## BOARD MEMBERS

Simmie Armstrong, M.D.	Pine Bluff
Gilbert Buchanan, M.D.	Little Rock
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Judy McDonald, M.D.	Little Rock
R. Wendall Ross, M.D.	Van Buren
Joe Stallings, M.D.	Jonesboro
Donald Steely, M.D.	Little Rock
Mary Lynn Watkins	Hospital Auxiliary
Harold Wilson, M.D.	Monticello
Ray Jouett, M.D.	Little Rock
Debbie Pike, R.N.	AR Home Health Agencies
John Burge, M.D.	Lake Village
Kenny Whitlock	Dept. of Human Services
Dale Nicholson	KATV Channel 7



# New Members

## FORT SMITH

**Kyle, Walter L.**, OB/GYN. Medical education, UAMS, 1976. Internship, UAMS, 1977. Residency, UAMS/AHEC-Fort Smith, 1979, and Tulsa Medical College, 1993. Board certified.

## HARRISON

**Chambers, Elizabeth "Sue"**, Pediatrics. Medical education, UAMS, 1964. Internship, San Diego County General, 1965. Residency, San Diego County General, 1966; UAMS, 1969; and Confederal Memorial, Shreveport, 1970. Board certified.

## HOPE

**Finley, George M.**, Family Practice. Medical education, UAMS, Little Rock, 1981. Residency, Louisiana State University Medical School, 1984. Board certified.

## JONESBORO

**Cohen, Evan S.**, Cardiothoracic & Vascular Surgery. Medical education, Baylor College of Medicine, Houston, 1983. Internship, University of Alabama at Birmingham, 1988. Residency, Baylor College of Medicine and University of Alabama at Birmingham, 1991. Board certified.

## LITTLE ROCK

**Angtuaco, Edgardo J.**, Radiology. Medical education, University of Philippines, Manila, Philippines, 1973. Internship, St. Barnabas Medical Center, 1976. Residency, Boston City Hospital, 1979. Board certified.

## RESIDENTS

**Avant, Michael G.**, Pediatrics. Medical education, University of South Carolina School of Medicine, Columbia, 1991. Residency, UAMS.


**Lipe, Carol A.**, Anesthesiology. Medical education, UAMS, 1989. Internship/Residency, UAMS. Fellowship, LeBonheur Children's Hospital, Memphis, 1993.

**McGhee, Michael A.**, Otolaryngology. Medical education, UAMS, 1993. Internship/Residency, UAMS.


## STUDENTS

Walter C. Archer  
Peter H. Ball  
Braun L. Borman  
Freddy D. Chrisman  
Gary A. Frankewski  
Joel S. Hardin  
Hassan A. Hassan  
Eric B. Henderson  
Carla R. Hicks  
Alice A. Hill  
Melinda L. Houston

Lee M. Johnson  
Brad L. Lindsey  
Bryan D. McDonnell  
Eric L. Reding  
Sherlita Reeves  
William P. Scott  
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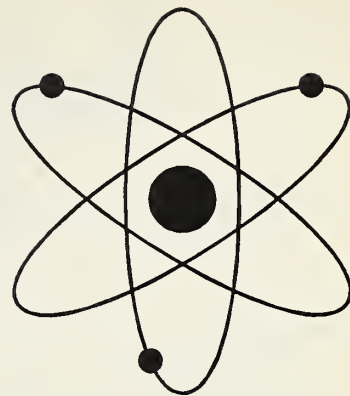
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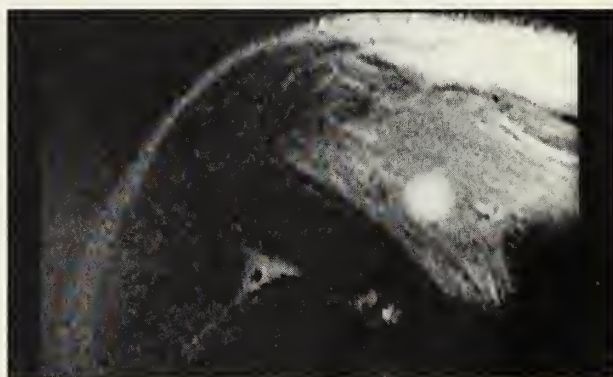
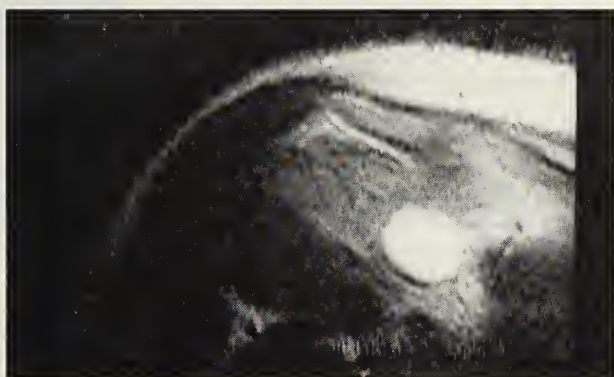
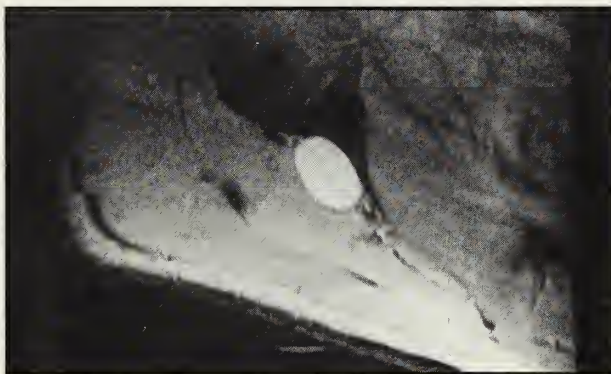
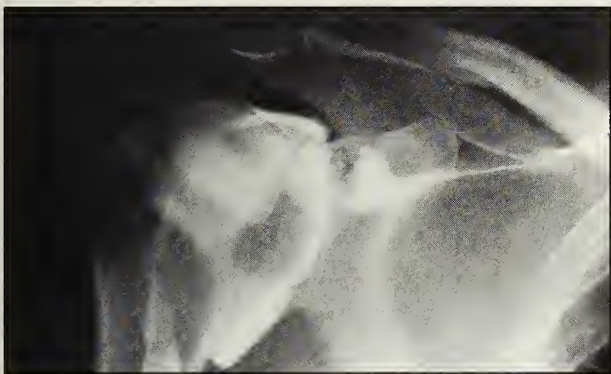
# Radiological Case of the Month



Steven R. Nokes, M.D.  
C. Lowry Barnes, M.D.  
David N. Collins, M.D.

## History:

This 37-year-old male presented with right shoulder pain and weakness. An arthrogram (Figure 1) and MR exam (Figures 2a-c) were performed.



*Top left:* Figure 1; *top right:* Figure 2a. *Bottom left:* Figure 2b; *bottom right:* Figure 2c.

# Ganglion cyst with suprascapular nerve entrapment.

## Findings:

The arthrogram is normal. The MR images reveal a 2 cm well-circumscribed nonhomogeneous mass in the spinoglenoid notch proven to be a ganglion cyst. There is increased signal (bright) within the infraspinatus muscle (Figures 2b and 2c) indicating isolated denervation.

## Discussion:

Suprascapular nerve entrapment is easily overlooked in the differential diagnosis of shoulder pain which includes rotator cuff tears, labral tears, calcific tendinitis, arthritis, bursitis, adhesive capsulitis and cervical radiculopathy. The suprascapular nerve is a mixed motor and sensory nerve that provides motor supply to the supra and infraspinatus muscles and carries pain fibers from the glenohumeral and acromioclavicular joints. Lesions in the suprascapular fossa produce atrophy of both muscles, while lesions in the spinoglenoid notch selectively affect the infraspinatus (as in this case). The syndrome is confined to men, and has an association with weightlifting.

Prior to the advent of MR imaging, the diagnosis was rarely considered until severe atrophy developed, resulting in prolonged recovery. A variety of other conditions cause injury or entrapment of the nerve including fractures, dislocation, penetrating trauma, tumors and thick or anomalous scapular ligaments. Arthrograms rarely demonstrate the ganglion cysts in this region, although they are felt to arise from the posterior joint capsule. CT and ultrasound have been reported to detect these lesions (which are not palpable) but lack the soft tissue contrast and overall utility of MR in evaluating a broad range of shoulder disorders.

## References

1. Fritz RC, Helms CA, Steinbach LS, Genant HK. Suprascapular nerve entrapment: evaluation with MR imaging. *Radiology* 1992; 192:437-444.
2. Balck KP, Lombardo JA. Suprascapular nerve injuries with isolated parapalysis of the infraspinatus. *Am J Sports Med* 1990; 18:225-228.
3. Ogino T, Minami A, Kato H, Hara R, Suzukik. Entrapment neuropathy of the suprascapular nerve by a ganglion. *J Bone Joint Surg (Am)* 1991; 73:141-147.

*Editor: Steven R. Nokes, M.D., is affiliated with Radiology Consultants in Little Rock.*

*Contributor: C. Lowry Barnes, M.D., is affiliated with Orthopedic Specialists in Little Rock.*

*Contributor: David N. Collins, M.D., is affiliated with Orthopedic Specialists in Little Rock.*



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**Arkansas Medical Society**  
**Political Action Committee**

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**Dr. Marvin Leibovich, M.D., FACEP**, recently received the Council Meritorious Service Award. The American College of Emergency Physicians (ACEP) presented with the award for his outstanding contributions to the ACEP Council, the forum representing ACEP chapters. The Council Meritorious Service Award is given to a member who has served as a councillor for at least three years and has made consistent contributions to the ACEP Council. The award was presented at ACEP's annual Scientific Assembly, held October 11-14, 1993 in Chicago.

Dr. Leibovich is the medical director for both the Arkansas Department of Health, Division of Emergency Medical Services, and the Emergency/Trauma Department and MED-FLIGHT program associated with Bap-

tist Medical Center in Little Rock. He is also an assistant professor of emergency medicine at the University of Arkansas for Medical Sciences campus.

**Dr. Van Smith, M.D., FACP**, Harrison, received the Robert Shields Abernathy Award for Excellence in Internal Medicine at ceremonies in the Convention Center in Little Rock during the annual meeting of the Arkansas Chapter of American College of Physicians.

The award, established in 1976 to recognize the distinguished career of Robert Shields Abernathy, M.D., Ph.D, FACP, and to promote excellence in internal medicine, is bestowed annually on an internist who has trained, practiced or taught in Arkansas and achieved distinction in the profession.

## Medicine in the News

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### Health Care Access Foundation Update

As of November 1, 1993, the Arkansas Health Care Access Foundation has provided free medical service to 6,736 medically indigent persons, received 12,942 applications, and enrolled 26,347 persons.

The program has 1,642 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

### 7th Annual Boone County Fish Fry

Dr. Robert and Cynthia Morris hosted the 7th Annual Boone County Legislative Appreciation Fish Fry held August 19, 1993 on the lawn of their Harrison home.

The Governmental Affairs Committee of the Boone County Medical Society sponsors the event each year to show their appreciation to the legislators and other elected officials of the area. CEOs of most local businesses, as well as leaders of community organizations were included.

Special guests this year were Senator Jon Fitch, Senator Steve Luelf, Representative Bob Watts, Representative Billy Joe Purdom, former Congressman John Paul Hammerschmidt, Dr. Charles "Shot" Rodgers,

AMS Governmental Affairs Council; Mr. Ken LaMastus, AMS executive vice president; Mr. Lynn Zeno, AMS director of Governmental Affairs; and Barbara and Dr. Mike Moody, AMS Governmental Affairs Council.

### Arkansas Medical Society Participates in Arkansas Physician's Opportunity Fair

The 19th Annual Arkansas Physician's Opportunity Fair was held October 28, 1993. This year had the largest attendance - ever, plus the largest number of residents to attend since 1987, the largest number of students to attend since 1980, and the second largest number of communities attending the Fair since 1981. In addition, Community Representatives' evaluations reflected this year's Fair was one of the highest rated ever.

The Arkansas Medical Society gave away the following door prizes (to residents) during the Fair:

**\$50 Gift Certificate for Outback Steakhouse**  
*won by Dr. Malcomb Baxter*

**\$50 Gift Certificate to one of three restaurants (your choice) - Graffiti's Italian Restaurant, 1620 Grill or the Purple Cow**  
*won by Dr. Kyle Roper*



# Resolution

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## **Robert A. Fisher, M.D.**

Whereas, the members of the Pulaski County Medical Society are saddened by the recent death of an esteemed colleague, Robert A. Fisher, M.D.; and

Whereas, his membership in this Society, the American Medical Association, the American College of Emergency Physicians and many other professional organizations gave evidence of his unwavering dedication to his profession; and

Whereas, his students in the Emergency Medicine Department at the University of Arkansas for Medical Sciences will remember him as a caring and competent teacher; be it therefore

**RESOLVED**, that this resolution be adopted and placed in the permanent archives of this Society; and

**RESOLVED**, that a copy be forwarded to Dr. Fisher's family as a token of our sincere sympathy; and

**RESOLVED**, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
October 20, 1993

By Order of the Memorials Committee  
Bruce E. Schratz, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

# In Memoriam

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## **Edward J. Bass, M.D.**

Dr. Edward Joseph Bass, of El Dorado, died Thursday, November 4, 1993. He was 46.

He is survived by his wife, Wanda, of El Dorado.

## **Samuel F. Brown, M.D.**

Dr. Samuel Franklin Brown, of Texarkana, Texas, died Saturday, October 30, 1993. He was 49.

Survivors include his wife, Susan Brown of Texarkana, Texas; two daughters, Suzanna May of Texarkana and Samantha Brown of Little Rock; two stepsons, William Taggart and Adam Taggart of Texarkana; his mother, Ruth Brown of Hope, Ark.; one brother, Charles Lee Brown of Springfield, Mo.; and one sister, Charlotte Goza of Houston, Texas.



Dr. Robert A. Fisher, 36, of Little Rock, Arkansas, died October 11, 1993. He was an Assistant Professor of Emergency Medicine at the University of Arkansas Medical Sciences campus, where he had served as Residency Director for the past five years, and had been a faculty member since 1987. He was an active member of the American Medical Association. He was a frequent recipient of campus teaching awards. Dr. Fisher was also the 1992 Southern Regional case Presentation Champion for the Society for Academic Emergency Medicine. A National Merit Finalist and Eagle Scout, he also became a Life Master in the American Contract Bridge Association at the age of 27, one of the youngest Life Masters in the United States. Dr. Fisher received a Bachelor of Arts Degree from Louisiana State University at Baton Rouge in 1978 and graduated in 1982 from medical school at UAMS, where he also completed the Emergency Medicine residency in 1987. A 1989 diplomate of the American Board of Emergency Medicine, Dr. Fisher served as Vice-President of the Arkansas Emergency Physicians Foundation, on the Advisory Board of Rape Crisis, and on the Board of Directors of the Arkansas Chapter of the American College of Emergency Physicians.

Contributed by the University of Arkansas for Medical Sciences, Division of Emergency Medicine

# Things To Come

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## January 14-15

**What's New in General Surgery: 16th Annual Surgical Postgraduate Course.** Hyatt Regency, Sacramento, Calif. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## January 16-18

**Ambulatory Obstetrics and Gynecology.** Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## January 22

**Current Concepts in Hemostasis and Thrombosis.** Cancer Center Auditorium, UC Davis Medical Center, Sacramento, California. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## January 23-26

**Fracture Management.** Resort at Squaw Creek, Squaw Valley, Calif. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## January 23-28

**20th Annual Midwinter Program in Continuing Medical Education for Psychiatrists.** Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Office of CME at UC Davis School of Medicine and Medical Center. For information, call (916) 734-5390.

## January 28-29

**Transfusion Medicine: Update 1994.** Seattle, Washington. Sponsored by the American Association of Blood Banks (AABB). For more information, call (301) 215-6482.

## January 29

**Advances in Cardiology.** Le Meridien Hotel, New Orleans, Louisiana. Sponsored by The Section of Cardiology in the Department of Medicine, and the Tulane University Medical Center, Office of CME. Six hours Category I credit offered. For information, call (504) 588-5466.

## January 29

**General Medicine Update for the Ophthalmologist.** Cancer Center Auditorium, UC Davis School of Medicine and Medical Center. Approx. 6 hours Category I credit offered. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## February 1-4

**HIV/AIDS and the Primary Care Practitioner - You CAN Make a Difference.** Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Category I credit: 15 hours. For more information, call (916) 734-5390.

## February 1-5

**19th Annual Meeting of the Alliance for CME.** Hotel del Coronado, San Diego, California. For more information, call Daniel E. Reichard, George Washington University Medical Center, (202) 994-4285.

## February 4-5

**12th Annual Infectious Disease Conference.** Hilton Hotel, Sacramento, Calif. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Category I credit: 11 hours. For more information, call (916) 734-5390.

## February 5

**Otolaryngology for the Primary Care Physician.** Hotel Intercontinental, New Orleans. Sponsored by the Tulane University Medical Center. Category I credit: 8 hours. For more information, call (504) 588-5466 or (800) 588-5300.

## February 11-12

**Incontinence Update.** Hyatt Regency Hotel at the Louisiana Superdome, New Orleans. Sponsored by the Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## February 14-16

**HMO Managed Care Policy Conference.** The Washington Hilton and Towers, Washington, D.C. Sponsored by the Group Health Association of America, Inc. For more information, call (800) 347-8074.



## February 18-20

**American Academy of Pain Medicine 1994 Annual Refresher Course and Conference.** Buena Vista Palace, Orlando, Florida. For information call Cathy Crabbe, (708) 966-9510.

## February 19

**Trends in Healthcare: The Adult Diabetic.** Windsor Court, New Orleans. Sponsored by the Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## February 20-25

**Emergency Medicine 1994: 17th Annual UCD Winter Conference.** Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Tulane University Medical Center. For more information, call (916) 734-5390.

## February 26

**Cardiology for the Primary Care Physician.** Cancer Center Auditorium, UC Davis School of Medicine and Medical Center. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## March 4

**20th Annual Diabetes Symposium.** Sheraton Sunrise Hotel, Sacramento, Calif. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Category I credit: 6 hours (approx.) For more information, call (916) 734-5390.

## March 5-10

**21st Annual Critical Care Medicine Course.** Marriott Hotel, Oklahoma City. For more information, call Ms. Dora Lee Smith, (405) 271-5904.

## March 6-11

**Update in Clinical Medicine.** The Radisson, Vail, Colorado. Category I credit: 19 hours. For more information call Steven Smith, George Washington University Medical Center, (202) 994-4285.

## March 12-13

**Laparoscopy in Urologic Surgery: Radical Perineal Prostatectomy.** Tulane University Medical School. Category I credit: 12.5 hours. Sponsored by the Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## March 17-19

**Human Genetics in Clinical Practice.** Holiday Inn Superdome, New Orleans. Sponsored by the Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

# THE BASES ARE LOADED

## AMS' at Bat

Don't miss the chance to get away and have some fun while you attend the Arkansas Medical Society annual convention in April!



**Golf Tournament for AMS Members, Clinic Managers and Exhibitors**

**on Thursday morning ♦ Welcome Reception on Thursday, followed by the 1st House of Delegates ♦ Blue Cross Blue Shield Reception on Thursday evening ♦ Shuffield Luncheon on Friday at noon ♦ A**



**Baseball Theme Party with the "GroanUps" on Friday evening ♦ Exhibits and CME Sessions on Thursday and Friday ♦ The Final**

**House of Delegates on Saturday morning ♦ Magical entertainment at the AMS Inaugural Banquet and the President's Reception.**



**Arkansas Medical Society  
118th Annual Session  
Excelsior Hotel & Statehouse Convention Center  
Little Rock, Arkansas April 7 - 9, 1994**

# ARKANSAS MEDICAL SOCIETY 118TH ANNUAL SESSION

## “THE BASES ARE LOADED . . . AMS’ AT BAT”



### Statistics: Alice G. Gosfield

Alice G. Gosfield practices law primarily in Philadelphia, Pennsylvania, and is also 'of counsel' for a law firm in Kansas City, Missouri. Ms. Gosfield has restricted her practice to health law and health care regulation since 1973, with a special emphasis on non-institutional reimbursement, medical staff issues, utilization management and quality assurance, fraud and abuse and peer review. A graduate of Barnard College and NYU Law School, she served as President of the National Health Lawyers Association from 1992-1993.

Ms. Gosfield has served on three committees of the National Academy of Sciences Institute of Medicine studying issues in utilization management and clinical guidelines and has consulted to the federal Agency for Health Care Policy and Research.

She publishes and lectures frequently on health law issues for groups including the American Medical Association, Medical Group Management Association, Group Health Association of America and American Bar Association.

She is on several periodical editorial boards including Medical Economics and is the consulting editor for Clark Boardman Callaghan's health law series and contributing editor for their annual Health Law Handbook. She has been listed repeatedly in The Best Lawyers in America (Health Law) and is a member of the American Medical Association's Consulting Network.

**First Feature Session: “Coping with  
the New Managed Care Paradigm”**

**Alice G. Gosfield**

*-- Friday, April 8, 1994 11:00 a.m.*

### Plus

- \*CME Hours & Exhibits
- \*Shuffield Lecture & Luncheon
- \*1994 AIDS Feature Session
- \*Entertainment



### Location

- \*Excelsior Hotel & Statehouse  
Convention Center
- \*Little Rock, Arkansas
- \*April 7 - 9, 1994



## **Infectious Disease**

December 9, 12:00 p.m.-1:30 p.m., Medical Center of South Arkansas, Conference Room 3, El Dorado. Presented by Dr. Terry Yamauchi, UAMS Outreach Program and sponsored by AHEC-South Arkansas. Category I credit: 1 hour.

## **4th Annual Physician Update**

February 12, 1994, 7:15 a.m. - 3:30 p.m., Center for Health Education, St. Vincent Infirmary Medical Center, Little Rock. Sponsored by St. Vincent Infirmary Medical Center and presented by the Office of Continuing Medical Education. Fee: \$25. Category I credit: 5.5 hours.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **FAYETTEVILLE-VA MEDICAL CENTER**

Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

Continuing Medical Education Luncheon, Jan. 14 & 28, Feb. 11 & 25, 12:30 p.m., AMI Ozark - Quapaw Room

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium

Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457

Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom

Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium

Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom

Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom

Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided

Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served

Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.

GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

Cancer Conferences, Thursdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., Conference Room 1

Breast Conference, 3rd Thursday, 7:00 a.m., Conference Room 1

GI Conference, 4th Friday, 11:30 a.m., Conference Room 1

Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.

Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library

Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.

Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.

Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

### **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

Chest & Problems Case Conference, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.

Medicine Conference, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.

Surgery Conference, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.

X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

# **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
 Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
 Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
 Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
 Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06  
 Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06  
 CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
 Cardiothoracic Surgery Conference, date, time, & location varies  
 Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
 Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
 Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
 CME Outreach Program, dates, times & locations vary  
 Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
 Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
 Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
 Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
 Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
 Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
 GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
 Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
 Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
 LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
 LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC  
 Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
 Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
 Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
 Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
 Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
 Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
 Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
 Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33  
 Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C  
 Neurosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
 Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
 OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
 OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
 Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
 Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
 Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
 Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
 Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
 Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
 Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue  
 Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
 Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
 Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
 Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
 Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
 Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room  
 Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D  
 Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
 Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
 Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
 Urology Journal Club, once a month, 5:00 p.m., VAMC-LR, 4D  
 Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D



*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

## **EL DORADO-AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

## **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

## **FORT SMITH-AHEC**

*Advances in Plastic Surgery*, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Tuesdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Harris Hospital Tumor Conference*, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.

Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

#### **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

#### **TEXARKANA-AHEC SOUTHWEST**

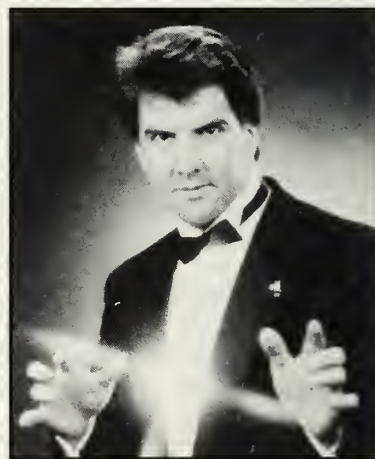
*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, every other 3rd Wednesday, 12:30 p.m., St. Michael Hospital  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Residency Noon Conference*, Tuesdays, Wednesdays and Thursdays, 12:30 p.m., AHEC-Southwest Family Practice Clinic  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Board*, Fridays, except 5th Friday, 12:00 noon, Wadley Regional Medical Center & St. Michael Hospital  
*Tumor Conference*, every 5th Friday, 12:00 noon alternates between Wadley Regional Medical Center & St. Michael Hospital  
*AHEC Tumor Board*, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

## **The Power of Performance**

### **The Real Magic is in You!**

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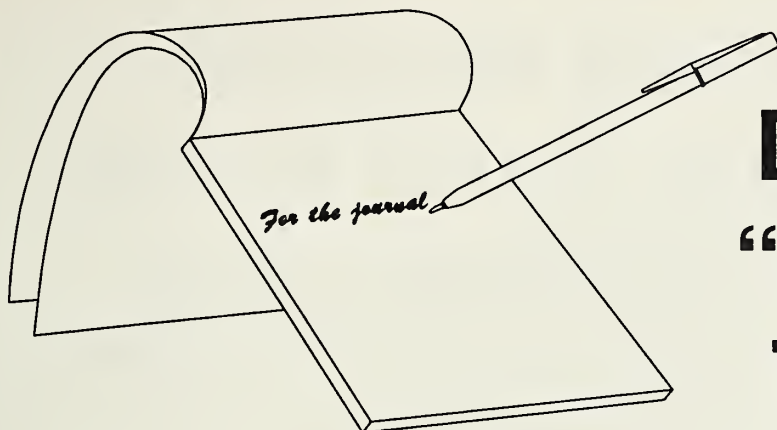
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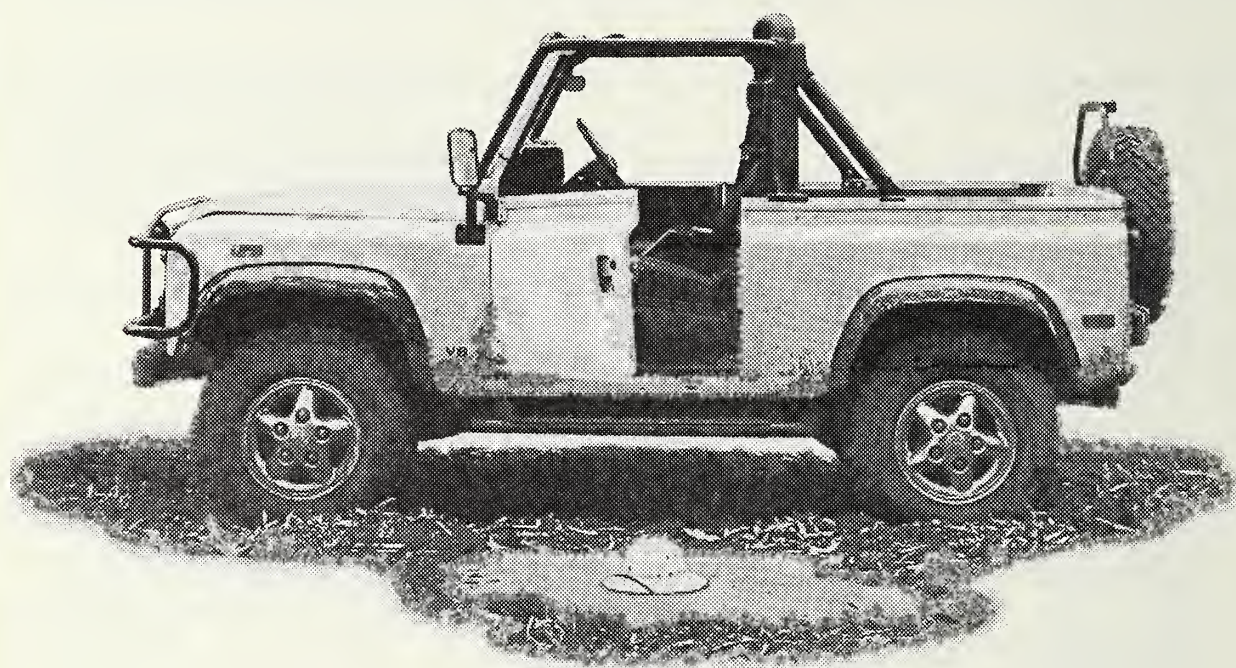
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- Teens and drug use
- A smokeless society
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- What's the value of organized medicine?
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- New treatments from Arkansas' medical facilities
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**1993  
Arkansas  
Medical  
Society  
Membership  
Roster**

**as of November 10, 1993**

**PAGES 352-367**

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# Arkansas Medical Society Membership Roster

as of November 10, 1993

# Denotes deceased member

## Arkansas County

Burleson, Stan W.  
Daniel, Noble B. III  
Guyer, G. L.  
Hestir, John M.  
John, Milton C. Jr.  
Millar, Paul H. Jr.  
Morgan, Jerry D.  
Northcutt, Carl E.  
Pritchard, Jack L.  
Speer, Hoy B. Jr.  
Speer, Marolyn N.  
Tracy, W. Lee  
Wagner, Taylor  
Yelvington, Dennis B.

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Burt, Frederick N.  
Garcia, Luis F.  
Gresham, Edward A.  
Grigsby, Benson  
Heder, Guy W.  
Holt, Terry  
Rankin, James D.  
Ripley, Curtis E. #  
Salb, Robert L.  
Thompson, Barry V.  
Toon, D. L.  
Walsh, Benjamin J.

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Baker, Robert  
Barker, Monty  
Barnes, Gregory  
Chatman, Ira D.  
Cheney, Maxwell G.  
Chock, Daniel P.  
Chock, Helga E.  
Clarke, James S.  
Condrey, Yoland M.  
Douglas, Donald S.  
Dyer, William  
Dykstra, Peter C.  
Elders, John Gregory  
Ford, William  
Foster, Robert D.  
Guenthner, John F.  
Hardin, Philip R.  
Johnson, Stacey M.  
Kelley, Lawrence A.  
Kerr, Robert L.  
Kilgore, Kenneth M.  
Knox, Thomas E.

Landrum, William  
Lincoln, Lance  
MacKercher, Peter A.  
Massey, James Y.  
McAlister, Matthew  
Neis, Paul R.  
Regnier, George G.  
Rigler, Wilson F.  
Robbins, Robert H. #  
Roberts, David H.  
Saltzman, Ben N.  
Sneed, John W. Jr.  
Stahl, Ray E. Jr.  
Sward, David T.  
TerKeurst, John  
Trager, Marc  
Tullis, Joe M.  
Turner, Frederick C.  
Wells, Gary  
White, Richard  
Wilbur, Paul F.  
Wilson, Jack C.  
Yoder, Robert Raymond

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Allen, L. Barry  
Allen, William M.  
Arkins, James  
Atkinson, Thomas  
Ball, Eugene H.  
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Benjamin, George  
Bledsoe, James H.  
Boden, Donna  
Boozman, Fay W. III  
Callaway, Michael  
Clemens, R. Dale  
Clower, John D.  
Cohagan, Donald L.  
Cole, Randall E.  
Compton, Neil E.  
Costaldi, Mario E.  
Dang, Minh-Tam  
Day, Geoffrey  
Denman, David A.  
Diacon, W. Lindley  
Donnell, Hugh Garland  
Donnell, Robert W.  
Elkins, James P.  
Ewart, David  
Fioravanti, Bernard L.  
Friesen, Douglas L.  
Garrett, David C. III

Goss, Stephen  
Harmon, Harry M.  
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Hitt, Jerry L.  
Hof, C. William  
Holder, Robert E.  
Horner, Glennon A.  
Howard, K. Lamar  
Hull, Robert R.  
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Knapp, James R.  
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McCollum, William  
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Mishkin, David  
Moose, John I.  
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Mulchin, Walter  
Mullins, Neil D.  
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Pickens, James L.  
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Rodgers, Harold  
Rollow, John A.  
Rolniak, Wallace A.  
Snyder, Norman I.  
Springer, Dan J.  
Steadman, Hunter M. Jr.  
Stinnett, Charles H.  
Stinnett, Scott G.  
Stolzy, Sandra  
Summerlin, William  
Swaim, Terry J.  
Swindell, William G.  
Tate, Jeffrey  
Treptow, Douglas  
Turley, Jan T.  
Ubben, Kenneth

Wachs, Theodore  
Waldon, Gene B.  
Warren, Grier D.  
Weaver, Donald D.  
Weaver, Robert H.  
Webb, William  
Weeden, Daniel S.  
Wilkerson, Danny  
Wright, Larry D.  
Youngblood, Thomas

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Bell, Thomas Edward  
Bennett, Joe D.  
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Collins, Kenneth  
Crider, James T.  
Daniel, Charles D.  
Dunaway, Geoffrey  
Ferguson, Noel F.  
Fowler, Ross E.  
Garland, William J. Jr.  
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Hoherock, Thomas R.  
Hutcheson, Galen  
Jennings, Larry B.  
Kim, Hyewon  
Kirby, Henry V. #  
Klepper, Charles R.  
Langston, Robert H.  
Langston, Thomas  
Laule, Alice R.  
Ledbetter, Charles A.  
Mahoney, Paul L. Jr.  
Maris, Mahlon O.  
Miller, Robert Jr.  
Padilla, Jose S. Jr.  
Rozeboom, Victor A.  
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Vowell, Don R.  
Williams, Rhys A.

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Marsh, James W.  
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Schultz, Wayne H.  
Wharton, Joe H.  
Wynne, George F.



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 Horton, Charles  
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 Martinson, Alice  
 McAlister, Robin  
 Nash, John R.  
 Spurgin, Randal Truman  
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 Taylor, Richard L.  
 Wallace, Oliver

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 DeRamos, Agapito Y.  
 Jackson, John III  
 Kronfol, Ned  
 Russell, John R.  
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 Thomas, H. W.  
 Tuangsithtanon, T.  
 Tvedten, Tom  
 Weaver, William J.  
 Wilson, Thomas C.

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 Balay, John W.  
 Ferrell, Griffith H. Jr.  
 Ford, Michael Ray  
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 Jansen, Mark  
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 Taylor, George D.  
 Teed, Frank S.  
 Toombs, Vernon L. #

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 Barnett, James C.  
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 Campos, Amador  
 Ewing, Jon R.  
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 Lewing, Hugh S.  
 Murry, J. Warren  
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 Vaughan, G. Lee

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 Hunter, Robert W. Jr.  
 Kelley, Charles W.  
 McMahan, H. Scott  
 Murphy, Fred Y.  
 Parkman, Robert L. Jr.  
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 Ruff, John L.  
 Strange, Vance M.  
 Walker, Jack T.  
 Weber, Charles #

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 Owens, Gastor B.  
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 Wells, Charles F.

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 Awar, Ziad  
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 Casey, Jason  
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 Cohen, Jeffrey O.  
 Cohen, Robert S.  
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 Cranfill, General L. III.  
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 Dickson, Glenn E.

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 Eddington, William R.  
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 Fowler, William  
 Garner, William L.  
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 Golden, Stephen C.  
 Gossett, Clarence E.  
 Goza, Gary R.  
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 Guinn, Donald R.  
 Hall, Ray H. Jr.  
 Hiers, Connie L.  
 Hightower, Michael D.  
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 Hubbard, William S.  
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 Huynh, Chanh V.  
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 Jiu, John B.  
 Johnson, John A.  
 Johnson, Larry H.  
 Johnson, Roehl W.  
 Jones, K. Bruce  
 Jones, R. J.  
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 Mahon, Larry E.  
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 McDaniel, Craig A.  
 McKee, Sanders  
 Modelevsky, Aaron C.  
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 Moseley, Claiborne II.  
 Nash, Jerry  
 Nixon, D. Allen Jr.  
 Owens, Ben Jr.

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 Price, Herbert H. III  
 Price, Joel A.  
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 Ricca, Gregory F.  
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 Rogers, James F.  
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 Sanders, James W.  
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 Skaug, Warren A.  
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 Young, S. Morris #  
 Young, William C. Jr.  
 Zurkowski, Thomas

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 Edwards, Henry N.  
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 Harford, Martin  
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 Sasser, L. Gordon III  
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 Travis, A. Lawrence

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 Ferguson, Scott  
 Ferguson, T. Murray  
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 Nadeau, Kenneth R.  
 Peeples, Chester W. Jr.  
 Pierce, Trent P.  
 Schoettle, Glenn P.

Schoettle, Steve P.  
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 Smith, Bedford W.  
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 Wah, John  
 Webb, Dan W.  
 Wright, William J.

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 Beaton, Kenneth E.  
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 Jacobs, James R.  
 Roberson, Charles

### **Dallas County**

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 Nutt, Hugh A.

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 Go, Peter Kong Hua  
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 Hoagland, Robert A.  
 Masquil, Filipe  
 Robinson, Guy U. #  
 Turney, Lonnie R.

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 Wilson, Harold F.

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 Holland, Rhonda  
 Hudson, Thomas F. III  
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 McChristian, Paul L.  
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 Humphreys, Robert P.  
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 Powell, Brenda  
 Queen, George P.  
 Rainwater, W. Sloan  
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 Russell, Mark  
 Sanders, Hallman E.  
 Schmidt, Clinton C.



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Simpson, John B.  
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Smith, John  
Smith, Phillip L.  
Sorrels, John W.  
Springer, Melvin R. Jr.  
Springer, William Y.  
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Stecker, Rheeta M.  
Stough, D. Bluford III  
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Thompson, Thomas P. Jr.  
Trieschmann, John W.  
Tucker, R. Paul  
Wallace, Thomas  
Walley, Luther R.  
Webb, Timothy  
Woodward, Philip A.  
Wright, Charles C.

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Irvin, Jack M.  
Paulk, Clyde D.

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Baker, Clark M.  
Boggs, Dwight F.  
Bonner, J. Darrell  
Brown, Peggy  
Cagle, Roger E.  
Collier, George H. Jr.  
Collier, Jon D.  
Crow, Asa A.  
Duckworth, Hillard R.  
Fonticiella, Adalberto  
Hardcastle, R. Lowell  
Harper, Bland  
Hazzard, Marion P.  
Hobby, George A.  
Jackson, Ron  
Kemp, Clarence  
Laffoon, Scott L.  
Lawson, J. Larry  
Martin, Richard O.  
Mitchell, Bennie E.  
Morrison, Jimmy  
Muse, Jerry L.  
Page, Billie C.  
Purcell, Donald I.  
Rollins, William  
Sellars, John R.  
Shedd, Leonus L.  
Sheridan, James G.  
Shotts, C. Mack Jr.  
Shotts, Vern Ann  
Smith, Norman

Watson, Samuel D.  
White, Robert B.  
Williams, Dwight M.  
Williams, Jacob M.

### **Hempstead County**

Finley, George  
Harris, Lowell O.  
Holt, Forney G.  
McKenzie, Jim  
Mercer, Lloyd  
Stevens, David G.  
Wright, George H.

### **Hot Spring County**

Berry, Frederick B.  
Bollen, A. Ray  
Brashears, Larry B.  
Burton, Bruce K.  
Cobb, Russell W.  
Ellis, C. Randolph  
Highsmith, Vivian F.  
Kersh, N. B.  
Loyd, Gregory M.  
Peters, Claude F.  
Tilley, Absalom  
Vaughan, John A.  
White, Bruce A.  
White, Robert H.

### **Howard-Pike County**

Dunn, Robert  
Floyd, Mark A.  
Gullett, A. Dale  
Hopson, Deanna  
Humphreys, T. J. Jr.  
King, Joe D.  
Patel, Madanmohan  
Peebles, Samuel W.  
Sayre, John  
Turbeville, James O.  
Ward, Hiram T.  
White, Phillip L.

### **Independence County**

Alexander, William Steve  
Allen, James D.  
Angel, Jeff D.  
Baker, John R.  
Baker, Robert V.  
Baxley, Paul J.  
Beck, Carl T. #  
Bess, Lloyd G.  
Bowman, Gary  
Brown, Hunter Lee  
Brown, Verona T.  
Davidson, Andy  
Davidson, Dennis O.  
Fulbright, Thomas  
Goodin, William H. Jr.  
Hays, Sarah F.

Jones, Edward J.  
Jones, Edward T.  
Kearns, Harry  
Ketz, Wesley J.  
Lambert, John S.  
Lytle, Jim E.  
McClain, Charles M. Jr.  
Melton, Clinton G.  
Moody, Lackey G.  
Neaville, Gregory  
O'Brien, Marcus D.  
Piediscalzi, Nicholas  
Raney, W. Troy #  
Scott, John G.  
Sherwood, Gary  
Simpson, Ronald  
Slaughter, Bob L.  
Sloan, Fredric J. II  
Stalker, James M.  
Strickland, Nathan E.  
Sutterfield, Terry F.  
Taylor, Chaney W.  
Taylor, Charles A.  
Tucker, Charles L.  
Waldrup, William J. III  
Walton, Robert B.  
Webster, Russell P.  
Zini, James E.

### **Jackson County**

Ashley, John D. Jr.  
Carney, J. W.  
Chauhan, Mufiz A.  
Cole, B. Eliot  
Dudley, Guilford M. III  
Falwell, K. Wade  
Frankum, Jerry M. Jr.  
Fremming, Bret G.  
Green, Roger L.  
Hergenroeder, Paul J.  
Hunt, Randall Evan  
Jackson, Jabez Fenton Jr.  
Junkin, A. Bruce  
Poon, Hon K.  
Reynolds, Roland C.  
Williams, Thomas E. #  
Young, Jack S. III

### **Jefferson County**

Anderson, Charles W.  
Armstrong, Simmie Jr.  
Atiq, Omar  
Atkinson, Evangelina  
Atkinson, Robbie  
Atnip, Gwyn  
Attwood, H.  
Bell, Carl H. Jr.  
Blackwell, Banks  
Bracy, Calvin M.  
Brooks, R. Teryl Jr.  
Bruton, J. Lewis

Buckley, J. Wayne  
Busby, John  
Butler, Robert C.  
Campbell, James C. Jr.  
Carlton, Irvin L.  
Cheek, Ben H.  
Clark, Charles A.  
Crenshaw, John  
Croswell, Kent  
Curry, Janet  
Davis, Charles M.  
Davis, Paul W.  
Dedman, John D.  
Deneke, William  
Duckworth, Thomas S.  
Fendley, Ann E.  
Fendley, Claude E.  
Fendley, Herbert F.  
Flowers, Martha A.  
Forestiery, Lee A.  
Freeman, William H.  
Frigon, Jacquelyn S.  
Glasscock, Robert E. #  
Green, Horace L.  
Gullett, Robert R. Jr.  
Henderson, Francis M.  
Hughes, L. Milton  
Hulsey, Matthew  
Hussain, Shafqat  
Hutchison, E. L.  
Hyman, Carl E.  
Irwin, Raymond A. Jr.  
Jacks, David C.  
Jacks, Dennis  
James, William J.  
Jayachandra, Paul David  
Jenkins, Bobby  
Jenkins, Mary Ellen  
Johnson, Horace  
Jones, Bobby Wayne  
Jones, James III  
Joseph, Aubrey S.  
Justiss, Richard D.  
Khan, Mahmood A.  
King, Yum Y.  
Langston, Lloyd G.  
Ligon, Ralph E.  
Lim, William N.  
Lindsey, James A.  
Lum, Don  
Lupo, David A.  
Lytle, John O.  
Mabry, Charles D.  
Marcus, Herschel  
McDonald, Robert L.  
McFarland, Mike S.  
Mehta, Shyam P.  
Meredith, William R.  
Miller, Donald L.  
Milligan, Monte C.  
Morris, Harold J.

Nagappa, Champa  
 Newan, Michael  
 Nixon, David T.  
 Nixon, William R.  
 Nuckolls, J. William  
 Pace, Rose A.  
 Pearce, Malcolm B.  
 Pierce, J. R. Jr.  
 Pierce, Reid  
 Pierce, Ruston Y.  
 Plaza, Jesus' A.  
 Pritchard, Ronald S.  
 Reid, Lloyene B.  
 Ridling, Anna T.  
 Roaf, Sterling A.  
 Roberson, George V. Jr.  
 Robinette, Joseph S.  
 Rogers, Henry L.  
 Rook, Michael J.  
 Ross, Robert L.  
 Samad, Syed A.  
 Samuel, Ferdinand K.  
 Shah, Sailesh N.  
 Shorts, Stephen D.  
 Simmons, Calvin R.  
 Simpson, P. B. Jr.  
 Smith, Paul L.  
 Stern, Howard S.  
 Sullenberger, A. G.  
 Townsend, Thomas E.  
 Tracy, C. Clyde  
 Waheed, Atiya N.  
 Walajahi, Fawad H.  
 Washington, Erma  
 Wilkins, Walter J. Jr.  
 Wineland, Herbert L.  
 Worrell, Aubrey M. Jr.

### **Johnson County**

Burch, Mary JaNell  
 McKelvey, Richard  
 Pennington, Donald H.  
 Shrigley, Guy P.

### **Lafayette County**

Harbin, Bradley  
 Hutson, Sanford E. III  
 Lee, Willie J.

### **Lawrence County**

Boozer, Ann  
 Hughes, Joe E.  
 Joseph, Ralph F.  
 Lancaster, Ted S.  
 Quevillon, Robert D.  
 Spades, Sebastian A. III  
 Sykes, Robert  
 Wilson, Stephen K.

### **Lee County**

Balke, Susan W.  
 Fields, E. C. #  
 Gray, Dwight W.  
 Ly, Duong N.  
 Wallace, Charles R.

### **Little River County**

Armstrong, James  
 Peacock, Norman W. Jr.  
 Shelton, Joseph Jr.

### **Logan County**

Alexander, Eugene  
 Buckley, Douglas A.  
 Daniel, William R.  
 Enns, Wayne P.  
 Harbison, James D.  
 Roberts, William J.  
 Smith, James T.  
 Ulrich, Guy  
 Williams, John R.

### **Lonoke County**

Abrams, Joe A.  
 Anderson, Leslie  
 Chapman, Jerry C.  
 Elam, Garrett  
 Gartman, Joseph F.  
 Holmes, Byron E.  
 Inman, Fred C. Jr.  
 Schumann, Gerald M.  
 Washburn, C. Yulan #

### **Miller County**

Alkire, Carey  
 Alston, Thomas  
 Andrews, A. E. Jr.  
 Barnes, Walter C. Jr.  
 Bivins, Franklin Jr.  
 Brown, Sam F. #  
 Burroughs, James C.  
 Clardy, James A.  
 Collins, Stanley  
 Cutler, Otis  
 Dildy, Edwin V. Jr.  
 Ditsch, Craig E.  
 Dodd, N. Leland  
 Dodge, John M.  
 Duncan, Donald L.  
 Eichler, Edward A. Jr.  
 Fisher, John  
 Ford, John Suffern  
 Fournier, Donald C.  
 Gabbie, Mark  
 Gillean, John A.  
 Graham, John  
 Green, R. Clark  
 Hall, Eric E.  
 Hall, Jon D.  
 Harrell, William B. Jr.

Harris, C. Lynn  
 Hillis, Thomas M.  
 Hodson, Gregory  
 Hughes, A. Keith  
 Hutcheson, Fred A. Jr.  
 Jean, Alan B.  
 Jones, John W.  
 Joyce, F. E.  
 Kemp, Karlton H.  
 Kittrell, James  
 Knowles, Stanley C.  
 Loe, Arlis W.  
 Mayo, Russell  
 McGinnis, Robert S. Sr.  
 Morris, Howard  
 Newton, Norris L. Sr.  
 Newton, Norris L. Jr.  
 Northam, Wanda M.  
 Peebles, Larry M.  
 Portis, Richard P.  
 Robbins, Joseph  
 Robertson, William  
 Rountree, Glen A.  
 Rountree, Susan  
 Royal, Jack L.  
 Salter, Wm. Richard  
 Sarrett, James  
 Schmidt, Howard  
 Shipp, G. Carl  
 Smith, Arnett D. Jr.  
 Solomon, J. Alan  
 Somerville, Patrick J.  
 Stockinger, Fred S.  
 Strickland, Glen  
 Stringfellow, Jerry B.  
 Thornton, Charles N.  
 Tyler, Richard L.  
 Vereen, Lowell E.  
 Wade, Billy  
 Wilhelm, Frieda  
 Wilson, Thomas Laurence  
 Wren, Herbert B.  
 Wright, James O. III  
 Yarbrough, Charles P.  
 Young, Mitchell

### **Mississippi County**

Abraham, Anes Wiley  
 Abramson, Lawrence  
 Bell, Mary C.  
 Biggerstaff, Jerry  
 Brock, Charles C. Jr.  
 Cullom, Sumner R.  
 Fairley, Eldon  
 Fergus, R. Scott  
 Hall, Leslie  
 Haynes, Max G.  
 Hester, Karen Calaway  
 Hester, Richard  
 Hubener, Louis F.  
 Hudson, James H.

Husted, G. Scott  
 Jones, Herbert  
 Jones, Joe V.  
 Lin, Ching-Shan  
 Osborne, Merrill J.  
 Pollock, George D.  
 Rhodes, Joseph  
 Rhodes, R. F.  
 Rodman, T. N.  
 Russell, James D.  
 Shaneyfelt, E. A.  
 Smith, Ronald D.  
 Williams, John

### **Monroe County**

Collins, Linda  
 David, Neylon C. Jr.  
 Pham, Dac Tat  
 Pupsta, Benedict F.  
 Stone, Herd E. Jr.  
 Walker, Walter L.

### **Nevada County**

McClard, Helen  
 Mesko, John D.  
 Rogers, Henry N.  
 Sosa, Humberto J.  
 Tinsesz, Thomas  
 Wood, John P.  
 Wynn, Chester

### **Pope County**

Ashcraft, Ted  
 Austin, Nathan  
 Bachman, David S.  
 Barron, William G.  
 Barton, A. Dale  
 Battles, Larry D.  
 Beavers, H. Kevin  
 Bell, Michael  
 Bell, Robert A.  
 Berner, Dennis W.  
 Birum, Patricia J.  
 Bradley, Stanley C.  
 Brown, Charles H.  
 Burgess, James G.  
 Callaway, Jody C.  
 Carter, James M.  
 Cloud, Joe A.  
 Crouch, James Jr.  
 Crumpler, Joe B. Jr.  
 Dunn, Donald L.  
 Ferris, Craig A.  
 Galloway, William W.  
 Gately, Stanley  
 Goodman, Robin Quinn  
 Haines, Lynn  
 Harrison, Rick  
 Hass, Farrell D.  
 Hendren, Mike  
 Henry, J. Arnold



Hill, Donald F.	Atkinson, William Jr.	Boger, James E.	Cash, Darlene
Honghiran, Ted	Austin, R. Lee #	Book, Lindy	Casper, Robert B.
Jones, Charles Jr.	Baber, John C. Jr.	Boop, Frederick	Casteel, Helen
Kerin, Douglas	Baber, John T.	Boop, Warren C. Jr.	Cathey, Janet
Killingsworth, Stephen M.	Backus, Joe T.	Bornhofen, John H.	Cathey, Steven
King, John W.	Bailey, H. A. Ted Jr.	Bost, Roger B.	Cavin, Lillian
King, W. Ernest Jr.	Baker, Glen F.	Bourne, David E.	Chaffin, Raines
Kolb, James M. Jr.	Baker, John W.	Bowden, Phillip	Chakales, Harold H.
Lawrence, Frank M.	Baker, Johnson	Bowen, W. Scott	Chandler, Billy M.
Lovell, Richard K. Sr.	Baker, Yvette	Bower, Charles M.	Chang, Chimin J.
Lowrey, Douglas H.	Baldwin, Maxwell R.	Boyd, Charles M.	Chappell, Carol W.
Lyford, Joe H. Jr.	Ball, Charles W. Jr.	Boyle, Ronald H.	Cheairs, David B.
Malone, George E.	Ballard, Clarence E. Jr.	Bozeman, Barbara J.	Cheairs, John T.
Massey, V. Rudolph	Barber, Jeffrey	Bradburn, Curry B. Jr.	Chisholm, Dan P.
Mauch, E. Jane	Barber, Laurie	Bradford, J. David	Choate, Robert B.
May, Robert H. Jr.	Barclay, David	Bradley, Joe F.	Christeson, William W. #
Meyer, Kelly H.	Bard, David S.	Brainard, Jay O.	Christian, John D.
Mobley, Max J.	Barger, Denver L.	Bressinck, Renie E.	Christiansen, Stephen P.
Monfee, Andrew M.	Barlow, Brian E.	Brimberry, Ronald K.	Chudy, Amail
Murphy, David S.	Barnes, C. Lowry	Brinkley, Roy A.	Church, Marion M.
Myers, J. Mark	Barnes, Reginald	Brizzolara, A. J.	Church, Michael
New, Kenneth O.	Barnes, Robert W.	Brizzolara, John Paul	Clark, J. Roger
Richison, George C.	Barnett, David	Broach, R. Fred	Clark, Richard B.
Riddell, C. Michael	Barnett, Troy F.	Brooks, David W.	Clift, Steven A.
Riley, Don C.	Barron, Edwin N. Jr.	Brown, Michael	Clifton, Cliff
Soto, Sergio F.	Barton, Gary	Brown, Pamela	Cobb, Jock S.
Speed, Darrell	Baskin, Barry	Brown, Scott H.	Cockrill, H. Howard Jr.
Stinnett, Thomas	Bates, Ramona	Brown, Steven L.	Cogburn, Bob E.
Stolz, Gerald A. Jr.	Bates, Stephen	Browning, Donald G.	Colclasure, Joe B.
Tapley, Thomas S.	Batres, Francisco	Browning, Stanley K.	Collins, David
Teeter, Stanley D.	Bauer, F. Michael	Brunson, Ashley	Collins, Kevin J.
Thurlby, W. Robert	Bauer, Frank M. Jr.	Buchanan, Francis R.	Cone, John
Turner, Finley P. II	Bauman, David C.	Buchanan, Gilbert A.	Cope, Michael
Turner, Kenneth B.	Bayliss, John M.	Buchman, Joseph A.	Corbitt, Mary
Wilkins, Charles F. Jr.	Beadle, Beverly	Buchman, Joseph K.	Cornell, Paul J.
Williams, David M.	Bearden, James R.	Bucolo, Anthony P.	Cosgrove, Kingsley W. Jr.
Young, Sandra S.	Beaton, J. Neal	Budhraj, Meenakshi	Cosgrove, Lisa
	Beck, Joseph II.	Buford, Joe L.	Coussens, David M.
<b>Pulaski County</b>	Becquet, Norbert J.	Burger, Robert A.	Craig, Marion S. Jr.
Abbott, William W.	Belknap, Melvin L.	Burnett, Hugh F.	Crawford, Cary M.
Abel, Lee C.	Bell, Rex H.	Burnett, P. Susan	Crews, J. Travis
Abraham, James H.	Bennett, Eaton W.	Burrow, Dennis R.	Crocker, Charles H.
Abraham, James H. III	Bennett, F. Anthony Jr.	Byrum, Jerry	Cross, J. B.
Abraham, Robert E.	Benton, William	Cain, Thomas	Crow, Joe W.
Adamez, James	Berry, Robert L.	Calcote, Robert A.	Crow, R. Lewis Jr.
Adamez, John	Bevans, David W. Jr.	Calderon, Vincent Jr.	Crowell, Karen D.
Adamson, James	Bienvenu, Gregory	Calhoon, J. Dale	Curtner, Byron D.
Alexander, Albert S.	Bienvenu, Harold G. III.	Calhoun, Joseph D.	Davie, Melanie
Alford, T. Dale	Bierle, Michael	Calhoun, Richard A.	Davis, Brett C.
Allen, Durward Jr.	Billie, James	Calkins, Joe B. Jr.	Davis, Carole
Allen, E. Stewert	Biondo, Raymond V.	Campbell, Gilbert S.	Davis, Claudia
Allen, John E. Jr.	Birkett, Ian McRae	Campbell, James W.	Davis, Glenn R.
Allen, Thomas	Bishop, Lisa M.	Caplinger, Kelsy J. III	Davis, J. Lynn
Alston, Phillip	Bishop, William B.	Capps, Dwight II	Dean, David M.
Andersen, Bruce J.	Bitzer, Lon	Carfagno, Jeffrey	Dean, Gilbert O.
Angeles, Jana	Black, H. Thurston	Carnahan, Robert G.	Deaton, C. William Jr.
Aquino, Al	Blackshear, Jack L. Jr.	Carson, Layne E.	Deer, Philip J. Jr.
Araoz, Carlos	Blankenship, William F.	Carter, Jerry L.	Deer, Philip James III.
Archer, Robert L.	Blasier, R. Dale	Carttar, Charles	Dennis, James L.
Armstrong, Howard	Boehm, Timothy	Caruthers, Samuel B. Jr.	Denson, William D.
Arrington, Robert	Boellner, Samuel W.	Casali, Robert E.	DesLauriers, S. Killeen

Dickins, John R. E.	Fuller, C. Dale	Harshfield, David Lee Jr.	Jansen, G. Thomas
Dickins, Robert D. Jr.	Fuller, C. James III	Hart, Thomas M.	Jefferson, Terry
Dickson, D. Bud	Fulmer, John M.	Harter, Scott	Johnson, Anthony D.
Dilday, James 'Kurt'	Galbraith, Robert C.	Hauer-Jensen, Martin	Johnson, B. Richard
Dillard, Daniel C.	Gardner, Guy F.	Hawley, Harold B.	Johnson, Ben D.
Diner, Bradley	Gettys, Joseph M. Jr.	Hayden, William F.	Johnson, Carl
Dixon, Keith A.	Gibbs, Mark	Hayes, J. Harry Jr.	Johnson, Dianne Flowers
Dodd, Doyne	Gibson, Gordon L.	Hayes, Richard L.	Johnson, Henry D.
Doncer, Richard P.	Giglia, Anthony R. III	Hayes, Sidney P.	Johnson, Kelli
Doucet, Marlon J.	Giles, Wilbur M.	Haynes, W. Ducote	Johnson, M. Bruce
Douglas, Warren M.	Gillespie, A. Tharp	Headstream, James W.	Johnson, Philip H.
Downs, Ralph A.	Gilliam, David	Hearnsberger, H. Graves III	Johnston, Dale E.
Dungan, William T.	Gist, Charles C.	Hearnsberger, Henry G. Jr.	Johnston, Kenneth
Dwyer, Gregory A.	Glenn, Wayne B.	Hearnsberger, John E.	Jones, Gail Reede
Eans, Thomas L.	Glidden, Michael L.	Hedges, Harold IV.	Jones, Garry L.
Easley, Edgar J. #	Glover, Lawson E. Jr.	Hedges, Harold H.	Jones, John C.
Easter, Rex M.	Glover, W. Clyde	Hefley, Bill F.	Jones, Kathleen C.
Edge, Otis H.	Golden, William E.	Hefley, William Jr.	Jones, Robert D.
Edmiston, Frank G.	Goldsmith, Geoffrey	Henker, Fred O. III	Jones, Roy
Eisenach, R. Jeffrey	Good, David M.	Henry, C. Reid Jr.	Jones, Sherman
Elders, M. Joycelyn	Good, Henry H.	Henry, Charles R. Sr.	Jones, William N.
English, Jim	Gordon, Vida H.	Henry, D. Andrew	Jordan, F. Richard
Eudy, Sidney	Gosser, Bob L.	Henry, G. Michael	Jordan, Randy A.
Evans, Billy	Goza, George M. Jr.	Henry, G. Morrison	Joseph, Ralph F. II
Evans, Clifford L.	Granger, William III	Henry, J. Charles	Joseph, William Frank
Eyre, Byron L.	Grant, Karen G.	Henry, J. Forrest Jr.	Jouett, W. Ray
Farmer, Joseph F.	Green, Benny J.	Henry, Richard Y.	Joyce, John W.
Farque, Greg L.	Green, William O. III	Henry, Robert L. Jr.	Junkin, Ruth H.
Farris, Guy R. Jr.	Greenway, C. Don	Henry, William T.	Kaemmerling, Raymond E.
Fazekas-May, Mary	Greer, Christopher	Henson, Gregory N.	Kahn, Alfred Jr.
Fernandez, Agustin	Greer, G. Stephen	Herbert, R. Wayne	Kane, James J.
Ferris, Ernest J.	Greutter, John E. Jr.	Herron, Jerry M.	Keathley, Susan A.
Fewell, Ronald D.	Grimes, H. Austin	Herron, John T.	Keeran, Michael G.
Fielder, Charles R.	Growdon, James H. #	Hickey, Joseph P.	Kellar, Stanley L.
Fields, Patrick R.	Guggenheim, Frederick G.	Hicks, David C.	Keller, Alfred W.
Finan, Barre F.	Guin, Jere D.	Hicks, David L.	Keller, Kevin
Fincher, Robert L.	Hagans, James III	Hill, Joy	Kelly, Karen
Finkbeiner, Alex E.	Hagler, James L.	Hixson, Marcia Lynn	Kennedy, Charles H.
Fiser, Martin	Hahn, Herbert	Hodges, J. Timothy	Kennedy, Eleanor E.
Fiser, Robert H. Jr.	Hall, A. D.	Hodges, Steven C.	Kennedy, H. Frazier
Fiser, William P. Jr.	Hall, A. David	Hoffmann, Thomas H.	Ketcham, Jeffrey
Fisher, Robert A. #	Hamer, Richard A.	Holland, Jay D.	Key, J. Michael
Fitzgerald, Charles	Hamilton, George Jr.	Hollenberg, Henry G.	Khan, Shagufta P.
Fitzhugh, A. Stuart	Hampton, John R. III	Holloway, J. Douglas	Kilgore, Reed W.
Flack, James V. Jr.	Hankins, Edwin III	Holmes, Harlan C.	King, Michael T.
Flanigan, Stevenson	Harber, Harley	Holt, Stephen	King, W. David
Flanigan, William #	Hardberger, R. E.	Holton, Jerry C.	Kittler, Fred J.
Fletcher, Anthony	Hardin, Ronald D.	Hough, Aubrey J. Jr.	Kizziar, Jim C.
Fletcher, Elizabeth D.	Harger, C. Harold	Houk, Richard	Klein, E. F. 'Bud' Jr.
Fletcher, Thomas M.	Hargrove, Joe L.	House, Aniel Jr.	Klimberg, V. Suzanne
Florez, James P.	Harper, Ernest H.	Houston, Samuel	Knott, Patricia A.
Flowers, W. Craig	Harper, Gary E.	Howell, Coburn S. Jr.	Knox, Michael F.
Floyd, Bill G.	Harrendorf, Cagle	Howell, Marsha T.	Kolb, Agnes J.
Foster, Gil	Harrington, Mariann	Hughes, Ronald D.	Kolb, David
Fraiser, Lacy P.	Harris, Donald R.	Hundley, John M.	Kolb, W. Payton
France, Gene L.	Harris, Frances	Hundley, Randal F.	Koonce, Thomas W.
Fraser, Eric A.	Harris, T. Stuart	Hutchins, Steven W.	Kovaleski, Thomas M.
Fraser, James H. Jr. #	Harris, W. Turner	Hutson, Harold G.	Kozberg, Oscar #
Frazier, Cynthia	Harrison, A. Vale	Jackson, J. Presley	Kozlowski, Karen J.
Frazier, G. Thomas	Harrison, Roy E.	Jackson, Morris A.	Kramer, Thomas
Freeman, Diane	Harrison, William	Jackson, Thomas	Kramm, Paul C.



Krulin, Gregory S.	McKinney, Carl	Norris, Lloyd P.	Rice, Charles
Kumpuris, Andrew G.	McKnight, C. Allen	Norton, George A.	Rice, James Curtis
Kumpuris, Dean	McMillin, F. Lamar Sr.	Norton, Joseph A.	Riddle, John F. Jr.
Kumpuris, Frank G.	McNair, James R.	Nowlin, James Bill	Riegler, N. W. Jr.
Kyser, James F.	McNee, Valerie	Nugent, Richard	Riley, William H.
Laakman, Robert W.	Meacham, Donald F.	O'Neal, Walter H.	Ritchie, Robert Ross
Lam, Bryon L.	Meador, Annette Parker	Oates, Gordon P.	Robbins, Kenneth
Lambert, Robert A.	Meadors, Frederick	Oddson, Terrence A.	Roberson, Michael C.
Landers, James H.	Means, Paul N. #	Ogden, Mahlon D.	Roberts, Kevin
Landgren, Robert C.	Medlock, Rickey D.	Oglesby, Walter R.	Rodgers, C. Dudley Jr.
Lane, John W.	Mellor, Roy II	Osam, Patrick N.	Rodgers, Charles H.
Lang, Nicholas P.	Mendelsohn, Lawrence A.	Osteen, Paul	Rogers, Charles Jr.
Langford, Timothy	Metrailler, James A.	Owings, Debra	Roman, Anthony
Langston, Harold D. #	Metzer, W. Steve	Owings, Richard	Rooney, Thomas P.
Laurenzana, Donald A.	Meziere, Tom	Ozment, Kerry	Rosenbaum, Carl A.
Lawson, Mason G.	Miers, Jane F.	Padberg, Frank T.	Ross, Ashley Sloan
Lehmborg, Robert W.	Miles, David A.	Paddock, George	Ross, Cynthia
Leibovich, Marvin	Miller, Forrest B. Jr.	Padilla, Fernando	Ross, Robert W.
Leonard, Donald G.	Miller, Raymond P. Sr.	Pappas, James J.	Ross, Robin
Leou, Frank J.	Milner, E. L.	Parker, J. Mayne	Ross, S. William
Lewis, Derek	Mitchell, George K.	Parkhurst, James	Rothert, Frances C.
Lewis, W. Sexton	Mizell, Philip	Parks, Greta	Rounsaville, Harry L.
Lile, Henry A.	Mizell, Walter S.	Parmley, Tim	Roy, F. Hampton
Lincoln, Ben M.	Moffett, T. Robert Jr.	Parnell, Clifton L. III	Ruggles, Dwayne L.
Lipke, Jay M.	Money, Wandal D.	Paulus, Thomas E.	Runyan, William A.
Livingston, Richard Lee	Montanez, Josue	Pearce, Charles	Russell, James B.
Loebl, Edward C.	Montgomery, Lori	Peeples, R. Earl	Rutherford, Reginald J.
Logan, Charles W.	Mooney, Donald K.	Peters, John E.	Rutledge, William L.
Love, Tommy L. Jr.	Moore, Burton A.	Peters, Phillip J.	Saer, Edward H. III
Lowe, Betty A.	Moore, J. Malcolm Jr.	Petrus, Gary M.	Sanderson, Marvin
Lucy, Dennis D. Jr.	Moore, Michael	Petursson, Gissur J.	Santoro, Ian H.
Ludwig, Frank R.	Moore, Rex N.	Pevahouse, Joe	Satre, Richard W.
Luttrell, Rex E.	Moore, Robert B.	Phillips, Bert L. #	Satterfield, John V. III #
Lyons, Virgle E. Jr.	Moore, Thomas	Phillips, Charles E.	Schlesinger, Scott Michael
Mabrey, William	Morris, Barbara	Phillips, Hannah	Schlicht, Lisa
Magie, Stephen K.	Morris, W. Dale	Phillips, James R.	Schmitz, Susan
Mallory, John A.	Morrison, Debra F.	Pierce, William	Schock, Charles C.
Maloney, F. Patrick	Morrison, Lynn	Pike, John D.	Schratz, Bruce E.
Maners, Ann	Morse, James C.	Pledger, Norman R.	Schroeder, George T.
Mann, R. Jerry	Morton, William J.	Pollard, Arlee E.	Schultz, John C.
Markland, Gary S.	Mulhollan, James S.	Pollock, Michael Marion	Schutz, Michael J.
Marks, Stephen R.	Mumme, David	Pope, Norton A.	Schwander, L. Howard
Martin, Kenneth A.	Mundie, J. Ryland	Porter, Robert Jr.	Scruggs, Jan W.
Martin, Richard H.	Murphy, Bruce	Potts, Jerry L.	Searcy, Robert M.
Mason, J. Zachary	Murphy, James E. Jr.	Power, Robert C.	Seibert, Joanna J.
Mason, William L.	Murphy, Jeanne	Prather, Jerry L.	Seibert, Robert
Matthews, Joseph W.	Murphy, Joseph	Price, Ben O.	Selakovich, Walter G.
Matthews, Robert R. #	Murphy, Randolph	Pringos, Andrew A.	Sessions, Louis II
McAdoo, Hosea W. Jr.	Murphy, Robert	Purdy, Harold D.	Sexton, Jon A.
McCarthy, Richard E.	Nagel, Fred G.	Pyle, Hoyte R. Jr.	Shannon, Robert F. #
McConnell, John D.	Nash, John C.	Quirk, J. Gerald	Sheppard, Joseph
McCracken, Gail Ann	Nayles, Lee	Ransom, John M.	Shock, John P.
McCracken, John	Nelson, Alvah J. III	Raque, Carl J.	Short, Harold K.
McCrary, George A.	Nelson, Carl L.	Ray, Verna	Shotts, Joseph
McCutcheon, Frank B. Jr.	Nestrud, Richard M.	Rector, Nancy F.	Shuffield, James
McDonald, James E.	Newbern, David	Reding, David L.	Silvoso, Gerald R.
McDonald, Judy	Newsum, Jon Kirby	Redman, John F.	Simmons, Orman W.
McDonald, William Glen	Newton, Fred E.	Reed, Ewing C. Jr.	Simpson, N. Henry Jr.
McGowan, Robert Jr.	Nix, Richard A.	Reese, William G.	Sims, James M.
McGrew, Robert N.	Nokes, Steven	Reid, Gene W.	Singer, Peter
McKelvey, K. David	Nolen, James E.	Rommel, Raymond	Singleton, L. Gene

Sinor, Elicia  
 Sipes, Frank M.  
 Skokos, C. Kemp  
 Slater, John G. Jr.  
 Slaven, John E.  
 Slayden, John E.  
 Sloan, Fay M.  
 Sloan, James M.  
 Smart, Douglas F.  
 Smelz, Johnny  
 Smith, Aubrey C.  
 Smith, Charles W. Jr.  
 Smith, David E.  
 Smith, Douglas B.  
 Smith, G. Richard Jr.  
 Smith, James L.  
 Smith, Mose III  
 Smith, Purcell Jr.  
 Smith, Thomas J.  
 Smith, Thomas W.  
 Smith, Tom  
 Snyder, Steven D.  
 Snyder, Victor F.  
 Somers, A. Jack  
 Sorrells, R. Barry  
 Sotomora, Ricardo F.  
 Squire, Arthur E. Jr.  
 St Amour, Thomas E.  
 Stallings, Walt  
 Stanley, Joe P.  
 Stanley, Robert  
 Stanton, T. Michael  
 Steele, William L.  
 Stefans, Vikki Ann  
 Stern, Scott Jeffrey  
 Sternberg, Jack J.  
 Stewart, Daryl  
 Stewart, Marquerite R.  
 Stokes, Bernard  
 Stone, Van D.  
 Storeygard, Alan R.  
 Stotts, John R.  
 Stout, Kimber  
 Strauss, Mark  
 Strobe, Steven W.  
 Stroope, George F.  
 Studdard, James D.  
 Sturdivant, Stephen  
 Suen, James  
 Sulieman, J. Samir  
 Sullivan, Charles D.  
 Sullivan, Jan R.  
 Sundermann, Richard H.  
 Swindoll, Bryant S.  
 Tahiri, Abdalla A.  
 Talbert, Gary Eugene  
 Talbert, Michael  
 Tamas, David E.  
 Tanner, James A.  
 Taylor, David R.  
 Taylor, Eugene H.

Tedford, John G.  
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 Texter, E. Clinton Jr.  
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 Thomas, Peter O.  
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 Thompson, S. Berry Jr.  
 Thompson, Steven M.  
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 Thorn, G. Max  
 Tilley, Steve  
 Tobler, H. Gareth  
 Towbin, Eugene J.  
 Tracy, Phillip A.  
 Trantum, Bill L.  
 Tressler, Samuel D. III  
 Trussell, Thomas W.  
 Tseng, Jyi-Ming  
 Tucker, R. Stephen  
 Tucker, W. Everett  
 Valentine, Robert G. Jr.  
 Vaughter, W. Roger  
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 Verma, Virendar K.  
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 Walker, Ronald  
 Walt, James R.  
 Waner, Milton  
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 Ward, Thomas  
 Warford, Walton R.  
 Warren, William Jr.  
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 Watkins, John Jr.  
 Watkins, John G. III  
 Watkins, Julia  
 Watkins, Larry S.  
 Watson, C. Robert  
 Watson, Daniel W.  
 Watson, Vye B.  
 Weber, Edward R.  
 Weber, James R.  
 Weber, Michael  
 Weiss, David W.  
 Weiss, Gerald N.  
 Welch, Samuel Bradley  
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 Westerfield, Frank M. Jr.  
 White, Oba B.  
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 Williams, Alonzo D.  
 Williams, C. David

Williams, G. Doyne Jr.  
 Williams, Paul E.  
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 Smoot, John D. #

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 Hill, Howell V.  
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 Martindale, J. L.  
 Martindale, Mark A.  
 Ramsay, Rex C. Jr.

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 Sudderth, Brian F.  
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 Thibault, Frank G. Jr.  
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 Thorn, Harvey Bell Jr.  
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 Alberty, Joe  
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 Bailey, Charles W.  
 Baker, Max A.  
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 Barker, Robert Jr.  
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 Barr, Marilyn  
 Barry, James Jr.  
 Beachy, Allen L.  
 Bell, Timothy  
 Berryhill, Richard E.  
 Berumen, Mike  
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 Brown, Byron L.  
 Brown, James A.  
 Brown, Richard  
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 Builteman, Cynthia  
 Builteman, James  
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 Busby, J. David  
 Cain, Martin  
 Carson, Randall L.  
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 Cassady, Calvin R.  
 Chalfant, Charles  
 Chester, Robert L.  
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 Coffman, Edwin L.  
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 Cook, Charles  
 Craft, Charles  
 Crow, Neil E. Sr.  
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### Sevier County

Buffington, Mike  
Couture, Susan E.  
Fotopoulos, Chris K.  
Hoyt, Jonathan  
Jones, Charles N.  
Mielnick, Alina

### St. Francis County

Ajamoughli, Ghaith  
Collins, E. Morgan Jr.  
Conner, George  
Crawley, Charles E.  
DeRossitt, James P. III  
Edwards, Carl B.  
Fong, Fun Hung  
Hammons, Edward P.  
Lopez, Ramon E.  
McGuire, Samuel A. III  
Meredith, James Jr.  
Schwartz, Frank R.  
Webber, David L.

### Tri-County County

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Arnold, Griffin II.  
Benton, Thomas H.  
Bozeman, Jim G.  
Campos, Louis  
Ducker, David E.  
Grasse, A. Meryl  
Grasse, John Jr.  
Helmling, Robert L.  
Jackson, George W.  
Krygier, Albin J.  
Lane, Robert C.  
Moody, Michael N.  
Relyea, William V.

Tatum, Harold M.  
Van Ore, Stevan Michael  
Wright, Donald

### Union County

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Barenberg, Robert  
Bass, Edward J. #  
Bevill, Gary L.  
Booker, J. Gregory  
Bowman, Raymond N.  
Bryant, D'Orsay III  
Carroll, Peter J.  
Cyphers, Charles D.  
Davis, Richard K.  
Deere, Joy  
Dixon, R. Mark  
Dougherty, Bert  
Dunn, Tom L.  
Duzan, Kenneth R.  
Elliott, Wayne G.  
Ellis, Jacob P.  
Fitch, Leston E.  
Forward, Robert B.  
Fraser, David B.  
Hill, Grady Jr.  
Jenkins, Chester W.  
Jones, Steve A.  
Jucas, Diana T.  
Kamdar, Vikram  
Kang, Gurprem Singh  
King, Billy D.  
Landers, Gardner H.  
Menendez, Moises A.  
Murfee, Robert M.  
Perry, Alvis T.  
Pillsbury, Richard C.  
Pirnique, Allan S.  
Ratcliff, John  
Rogers, Henry B.  
Sample, Dorothy C.  
Sarnicki, Joseph  
Scurlock, William R.  
Seale, James E. Jr.  
Smith, George W.  
Stevens, Willis M. Jr.  
Talley, H. Aubry  
Thibault, Frank G. Sr.  
Tommey, C. E.  
Tommey, Robert C.  
Turnbow, R. L.  
Ulmer, Minna Irene  
Vasan, Srin  
Vora, Chetna S.  
Warren, George W.  
Weedman, James B.  
Williamson, John R.  
Wilson, Larkin M. Jr.  
Yocum, David M. Jr.  
Zahniser, Donna J.

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Pearce, Charles G.  
Starnes, Harry  
Stuteville, Orion H.

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Albright, Spencer III  
Applegate, C. Stanley Jr.  
Arnold, James  
Atwood, H. Daniel  
Baggett, Jeff J. #  
Bailey, Donald  
Bailey, Scott  
Baker, C. Murl Jr.  
Baker, Donald B.  
Baker, James  
Beckman, James Jr.  
Benson, Stuart  
Blankenship, James  
Bond, Walter M.  
Bonner, Mark  
Box, Ivan H.  
Boyce, John M.  
Bredfeldt, Raymond  
Britton, Lewis  
Brooks, W. Ely  
Brown, Bruce B. Jr.  
Brown, Craig  
Brown, David L.  
Brunner, John A. III  
Burnside, Wade W. Jr.  
Burton, Anthony R.  
Butler, G. Harrison  
Cale, Charles  
Cameron, Mark  
Carver, Joel D.  
Chase, Patrick R.  
Cherry, James F.  
Churchill, David  
Coker, Tom P.  
Coker, Tom P.  
Cole, George R. Jr.  
Cooper, Craig  
Councille, Clifford C. Jr.  
Crittenden, David R.  
Crocker, Thermon R.  
Davis, David A.  
Davis, Randall  
DeValle, Oscar  
Decker, Harold  
Dodson, C. Dwight  
Dollins, Stephen  
Dorman, John W.  
Duncan, Philip E.  
Dykman, Thomas R.  
Eck, Gareth  
Edmondson, Charles T.  
Fincher, G. Glen  
Fish, Ted J.

Fossey, Carol  
Garbutt, Leopold H.  
Gardner, Buford M.  
Garner, Hershel H.  
Ginger, John D.  
Gray, Dalton L. II  
Grear, Danna  
Grote, Walton  
Haisten, James  
Hall, Ben  
Hall, Joe B.  
Harper, Richard  
Harris, Murray  
Harris, Paul L.  
Harris, W. Duke  
Harrison, William F.  
Hart, Hamilton R.  
Haws, Karl W.  
Haynes, James  
Hayward, Malcolm L. Jr.  
Hedberg, Curtis  
Heinzelmann, Peter R.  
Hendrycy, Paul R.  
Henry, Morris M.  
Higginbotham, Hugh B.  
Higginbotham, William  
Hoffman, Carl E.  
Holden, Donnie  
Hui, Anthony  
Hurlbut, Kevin  
Hutson, Martha  
Inlow, Charles W.  
Johnson, Stephen P.  
Jones, Edwin C.  
Knox, D. Luke  
Koehn, Laura J.  
Kraichoke, Saran  
Landrum, Leslie G.  
Lesh, Ruth E. #  
Litton, Eva W.  
Long, Robert M.  
Lushbaugh, Harmon #  
Magness, C. R.  
March, Allan  
Martin, F. Allan  
Martin, William C.  
Mashburn, James D.  
Mauro, Kirk  
McAlister, Joseph H.  
McAlister, Mitchell  
McAllister, Max F.  
McBee, Sara  
McDonald, James E. II  
McElroy, Kellye  
McEvoy, Francis  
McGhee, Linda M.  
McGowan, William  
McNair, William R.  
Miller, Charles H.  
Mills, William C. III  
Moore, Arthur F.

Moore, James F.  
Morse, Michael  
Mullis, R. Jay  
Nettleship, Mae B.  
Nowlin, William B.  
Oates, Randall B.  
Ortego, Terry J.  
Pang, Robert  
Park, John P.  
Parker, Joe C.  
Parker, Lee B. Jr.  
Patrick, James K.  
Pesnell, Larkus H.  
Pickett, James D.  
Pickhardt, Mark G.  
Pope, Kevin L.  
Power, John R.  
Proffitt, Danny L.  
Raben, Cyril  
Raben, Susan  
Ratcliff, David  
Reese, Valerie  
Riddick, Earl B. Jr.  
Riner, Dan M.  
Rogers, David L.  
Romine, James C.  
Ross, Joseph  
Rouse, Joe P.  
Runnels, Vincent B.  
Sandefur, Barbara A.  
Sexton, Giles A.  
Shaddox, T. Stephen  
Sharp, Jim D.  
Siegel, Lawrence H.  
Simmons, Thomas  
Singleton, E. Mitchell  
Sisco, Charles P.  
Slezak, James  
Smith, Austin C.  
Thomas, Joanna M.  
Titus, Janet L.  
Tuttle, Larry D.  
Ureckis, David  
Ward, H. Wendell  
Weed, Wendell W.  
Weiss, John B.  
Wheat, Ed Jr.  
Whiteley, Andre  
Whiting, Tom D.  
Whitney, Richard  
Wilson, Robert B. Jr.  
Wood, Jack A.  
Wood, Russell Hunter  
Woods, Elizabeth Ann

### White County

Asbury, Dale W.  
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Bell, John  
Blue, Glen T.



Blue, Leon R.	Harris, Walter P.	DeLoach, John Jr.	Langston, James David
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Brown, Terry Mac	Luker, Jerome H.	Dobbs, John C.	Lennon, Barbara M.
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Collier, Steven F.	Maupin, James L.	Dotson, Richard A.	Linzman, Rod F.
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Lowery, Benjamin R.	Bertelsen, Richard A.	Guard, Peggy K.	Owen, Richard Jr.
Lowery, Robert D.	Beverly, Carolyn	Hall, R. Whit	Plunk, Hermie G.
Maguire, Frank C. Jr.	Biton, Victor	Harden, V. Anthony	Porter, Neill C.
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Meacham, Kenneth R.	Bodemann, Donald R.	Hardy, Kyle G.	Rader, George
Millstein, David	Bonner, Cynthia	Hargrove, Kevin W.	Rayburn, John
Moore, Donald	Borklund, Patty	Harper, Donald	Reddy, Krishna
Nevins, William H.	Borland, Judy	Harrell, James Jr.	Reese, Ronald R.
Norris, E. Lloyd	Box, Jim F.	Harris, Russell	Reid, Tyra Mona
Ransom, Clarence E. Jr.	Boyd, Anita	Haut, Dawn L.	Reinhart, Jeffrey
Rasberry, Ronnie D.	Brannon, Dabney	Hayes, John	Rice, Robert E.
Rodgers, Porter R. Jr.	Braswell, Thomas	Hickman, Michael P.	Robbins, Bruce
Schwartz, Stanley S.	Broadwater, John Ralph Jr.	Hicks, Charles E.	Robbins, Mark
Shultz, Sam L.	Brodsky, Michael	Hillyer, John	Roberts, Terence J.
Simpson, James A.	Brown, Raeford Jr.	Hilman, Michael G.	Robinson, Dan
Smith, Bernard C.	Brown, Randel	Holland, Jerry	Robinson, Paul F.
Smith, Bob W.	Bumpers, Paul	Hopkins, Robert Jr.	Rochelle, Joe
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Thompson, Bruce	Campbell, Charles E. Jr.	Ivey, Traci	Schellhase, Dennis E.
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White, William D.	Carney, John	Jabbour, J. T.	Schonefeld, Michael D.
White, William M.	Carpenter, James	Jackson, Richard	Schonefeld, Pamela
Williams, W. Curtis	Carter, Inge Renate	Jasin, Hugo	Schutze, Gordon E.
Yates, Terrence	Cesar, Luis Geraldo G.	Karkos, Jerie	Shah, Ashok C.
<b>Woodruff County</b>	Chandler, Rodney	Karlson, Karl Jr.	Shah, Hemendra
Hendrixson, Basil E.	Chu, Tommy D.	Keith, Sharon C.	Shahbandar, A. B.
Rowe, James E.	Clark, James F. Jr.	Kendrick, Carl M.	Sharkey, Paul Jr.
<b>Yell County</b>	Cofer, Thomas	Khan, Mohammed B.	Sharma, Bimlendra
Bull, L. J.	Cooksey, Crit	Kinard, Hugh	Shewmake, Kristopher B.
Graves Tippin, Kim	Cunningham, James	Kirchner, Jeffrey	Shotwell, Monica R.
	Dallaire, Bob	Krebel, Steven R.	Sloan, Eugene E.
	Daniel, Robert G.	Lange, Bernadette	Smith, Eugene III

Smith, Richard  
 Smith, Samuel D.  
 Sousan, Leo  
 Spencer, Julia  
 Stagg, Stephen W.  
 Stair, J. Michael  
 Stephens, Wanda  
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# A Tarnished Image

W. Ray Jouett, M.D.  
Chairman, Arkansas State Medical Board

*[EDITOR'S NOTE: On Friday, March 26, 1993, Dr. Jouett concluded his year as President of the Neurological Society of America by giving the following speech.]*

One year ago, Dr. Russell Travis brought to you some disturbing problems concerning reimbursement and legislation at the National level. I do not plan to follow with information such as was outlined at the last Presidential address and would doubt that very little has happened over the past year but, rest assured, a year from now that will not be the case.

I would like for you to think with me for a short period of time, today, concerning the image of the physician, freely admitting that it is badly tarnished, and try to present some thoughts as to the reason the medical profession has the image that it carries today.

The physician in this country, from the early 1900s to at least 1960, was looked upon with great respect, and to a large degree, the physician was thought of as a scholar. He was a confidante and was relied upon as a trusted friend. Unfortunately, that relationship is not maintained today, and I dare say that we are not going to see that type of physician and patient camaraderie in the near future.

Not long ago a poll was conducted by the AMA, which stated that 68% of the people felt that physicians were not really concerned about them. Sixty percent felt the physician's main interest was making money, and some 27% felt the physician's fees were reasonable. Hopefully, it will be worth our time to look briefly at some historical facts, and look at some information that we know from our association with other physicians, look at the education process of the past and the present for the physician, and see if there is anything in that information that could help us understand what has happened with our relationship in the public.

At the turn of the century, there was a large number of medical schools and a sizable proliferation of physicians across this country. There were little, if any, standards that the medical schools followed. There was

no accreditation that was of significance. Many physicians, at the turn of the century, "read medicine" with another physician and, after a period of time, he/she was granted a license for the practice of medicine.

Dr. Abraham Flexner was commissioned to make a study of medicine in this country, specifically the medical schools and their curriculum. That report was published in 1910, and from it came a standardization for the educating of the physician. That report has held and been used for approximately 50 years. At the turn of the century, there were 160 medical schools operating in the United States and the quality of the schools had much to be desired.

Following the Flexner report, there was an elevation of the standards of medical education that led to the demise of many of the substandard institutions and was responsible for slowing the pace for the development of new schools. By 1960, the number of medical schools accredited in the United States by the Liaison Committee of Medical Education (LCME) stood at 86. There was a concern in 1960 that we did not have enough medical schools, we were not graduating enough physicians and, because of that stimulus, 40 more medical schools were developed by 1980. Since 1980, there has been one additional school, which brings the number now to 126.

The 126 institutions that now exist probably have little resemblance to the schools that were organized and reassessed after 1910. As we approach the end of the 20th century, we are all concerned about the plight of medicine, and the question to be asked is are we producing physicians that will perform well in the 21st century.

Prior to World War II, there were fewer medical schools and their concern at that time was to produce physicians. The medical schools were not involved in biomedical and behavioral research, which has been responsible for developing large, complex research institutions and, as a by product, they seem to also pro-

duce physicians. Following the development of World War II, there was a rush to develop more physicians. Many people were accepted into medicine who entered the field to avoid military service and also to obtain tuition from the Federal government. The pace probably never slowed following World War II and, perhaps, an indictment could be made in that regard.

In addition to the development of research institutions, there came a demand for health insurance. In the 1960s, everyone seemed to be interested in mobilizing for a great capacity for training health professionals. In 1965, Medicare came upon the scene, and medicine has not been the same since.

I am not a medical educator but have been interested and concerned for some time with what I see as totally foreign to me in regard to the training I received in medical school. I have not yet been convinced that the present method is that superior. Dr. Abraham Flexner, in his exhaustive report for reforms in 1910, outlined medical education that remained well enconced into at least 1960. Many of you remember well the types of curriculum of which you were exposed.

Flexner's recommendation consisted of the first two years of solid grounding in the biomedical science of anatomy, biochemistry, physiology and microbiology, which was followed by clinical relevant transition courses such as pharmacology, pathology and with some introduction into clinical medicine. The third and the fourth years were exposure to clinical medicine. To some degree, this recommendation by Flexner is still followed, but students are now, at the end of the first year, selecting electives, making decisions on the specialty of medicine of which they will become involved, and so tailoring their remaining time to offer all of the help necessary for that particular specialty. It seems illogical and ludicrous that a student with one year of matriculation would be able to make decisions concerning what he/she is planning to do the remainder of their life in medicine. Also disturbing, if you tailor your training, obviously a lot of other basic opportunities are going to be lost in the well-rounded development of the student of medicine.

One would get the impression that many of the medical students are looking at a highly paid specialty as opposed to being exposed to medicine and then make the decision, which should not come until following the year of internship. Internships have been discouraged, however, some schools are beginning again to utilize the internship as a part of the postgraduate training.

The Council on Graduate Medical Education feels the ideal number of generalists from the medical schools should be at least 50% and would strive for 70%. However, only approximately 30% become family practitioners or primary care physicians. Again, a point to consider is the high paying specialties and the need for someone to fill a slot in a training program, which has

not led to good screening of people that are placed in residency training of the different specialties. It would seem with the proliferation of physicians that a better selection of students should occur over the next several years.

There are 1300 hospitals in this country involved in medical education but approximately three-fourths of all of the medical students train in 388 hospitals. In 1992, nearly 16,000 were expected to matriculate at United States medical schools and also, that same year, 15,365 students were graduated, which was somewhat lower than the 16,343 that graduated in the peak year of 1984. The 1992 graduating class is still about double the size of its class in 1960, and continues to increase in the ratio of physician to population. The consequence of this great number has produced a lot of debate. Certainly we can gage the physician supply, but we cannot gage the demands for physician services.

Some point to the development that could readily absorb an increasing supply of physicians, such as the aging of the physician population, the emergence of new disease, such as acquired immune deficiency syndrome, the need to staff preventive and health promotion initiatives and change the social policy that extends access to medical care to those currently under served. Some argue that this would lower the cost of medical care. We are all aware that the increased amount of physicians has not lessened the health care costs.

The cost of medical education is not cheap, and medical schools, we're told as a matter of principle, try to take the most worthy candidates for admission regardless of their ability to pay. The cost of attending medical school rose significantly in the late 1970s, probably to some degree because of inflation that was present at that point. The increase in tuition and fees has continued through the 1980s and into the 1990s and, in the last five years, those increases have kept pace with inflation. The median annual tuition at a private medical school is about \$19,000 a year and, at a public or state medical schools, it's \$6,600 a year and for non-residents it's \$15,000.

Because of the increasing cost, there has been a growing need for scholarship funds and low interest subsidized loans. Loans constituted the major part of \$826 million in student financial assistance in 1990 and 1991. More than half of this amount was from the Federal Stafford loans, which is subsidized by the federal government. The interest on these loans is also subsidized while the student is in training or in an eligible deferment program. Another loan of significance is the Health Education Assistant Loan, known as HEAL, with 16% of the loans coming from this agency. The interest accrues to the borrower as a result of this commitment, and, upon graduation or at the completion of his training, the student has a formidable debt. We return, again, to the medical student who has graduated



ing with outstanding loans, and they are looking for the high yield and high priced specialties. I'm not sure that loaning students this amount of money so that they are encumbered at the time of graduation should be the way to proceed. The public is also aware of the abuse of these loans because we notice publicly of people who are sued by different agencies, refusing to pay back the debt and pay the interest.

It is not my intention to indict the academic institutions nor define people who staff those institutions, nor is it my intention to indict the American Medical Association because they have not done all of the necessary things to brighten the image of medicine. This is a multi-faceted problem that has to be evaluated at many levels.

There are problems with medical training, but there are also problems with the pre-medical training in that many people are denied access to medical education because of their background and training, who would make excellent, caring and compassionate physicians. The MCAT is developed to test the students primarily on scientific memory, and that hardly seems the appropriate way to judge an individual who is applying for medical school when that should be only a small part of his pre-medical educational background. It would seem more logical to omit much of the scientific background material that the pre-medical student has to digest and become more concerned with developing a background in the humanities and the classics, which would bring back to us some of the earlier standing of the physicians who were looked upon as men of learning.

We need to devote the pre-medical part of this education process to educating, not preparing, a robot technician that can recite pages of scientific information. The foundation of the student in the humanities has all but disappeared because this student must compete in the scientific field with his peers at the MCAT level. This was pointed out so vividly in the eloquent address by Jost Michelsen in his Presidential address in 1988.

Having made a bland indictment toward medical education, there are some things that should be inculcated in the medical curriculum: (1) There is a real need in the medical curriculum for lectures, seminars and some inducement to the student to understand his role in the community. The public looks upon the physician as someone who takes but is reluctant to give back to the community, other than what he considers to be his time in the practice of medicine. (2) There needs to be a place in the pre-medical education that deals with basic economics. The physician is looked upon as the poorest businessman in America, and the reason being that he has had no background in economics. (3) There needs to be courses or seminars on the development of relationships with those that are ill, aside from the treatment of disease. The student is exposed to fine, excellent professors who are skilled in their particular field,

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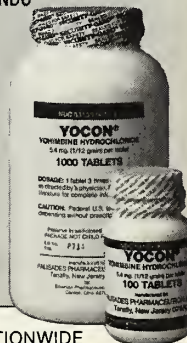
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but many of the mundane activities, such as speaking to the families of the sick are, at times, done by residents and interns. Medical students need to learn how to communicate with families of people that are ill. Physicians that are caring for a patient need to personally speak with the family when there has been a death or there has been a worsening of the patient's condition. Medical students need to learn how to tell a father with six children that his wife has just died or how to tell a father and mother that their six month old child has died. Sending the chaplain to tell them is not the way to deal with the problem. (4) There needs to be classes on substance abuse at probably all levels of the medical curriculum. This is a problem that no one cares to deal with, but it is a recognized fact that 15% of all physicians will, at some point, become incapacitated because of substance abuse. This is an awful waste for anyone, but especially for a physician who has devoted years of study and has years of productivity ahead of him.

It is a realization that medical education cannot foresee all of the problems that need to be addressed and does not have the time to address these problems in the development of the physician. There has to be some help also, on a peer level, and it should be the responsibility of the peers to help the young physician and not be concerned about this physician because of competition. There is a resistance on the part of the established physician to welcome new physicians into the community and discuss with him fees and to help him become involved in the community. This is a responsibility that we bear and, perhaps might be helpful in preventing the obnoxious advertising that goes on even in the daily news, on TV and in periodicals.

## STATE BOARDS

There is a perception on the part of the American people that there is a "doctor conspiracy" to protect the incompetent physician and this would also include the protection of the physician that is a drug abuser. We see this at many levels, but I think one of the places where we see much of the criticism arising is at the level of the state Medical Boards, which are charged with protecting the citizens against incompetent physicians. Many feel that the state Boards do not do an adequate policing of the physicians of which they license.

There are certainly plenty of well publicized failures on the part of the present state Boards. In fact, barely one half of one percent of physicians have ever faced any type of state sanction within recent years. The Physician's Data Bank that was opened last year is now being challenged by the public to be made open to anyone that wishes to review it. The patient has also become increasingly interested in doctor watching and, it is my perception, that doctor watching is going to

become as popular as watching members of Congress. We all are seeing the results of the public's displeasure with politicians. We will not escape.

The PRO was to be the great watch dog and the public envisioned this, likewise, as being an agency to identify substandard physicians. The public feels that this has failed and, certainly, we know that it has failed because it actually was not set up to deal with substandard physicians but was attuned to trying to detect fraud on the part of the physician and try to save money. As you know, it was not successful at either. Because of the fact that the PRO was not cost effective, it is being discontinued and a new force of action is being started by the Federal government.

Physician discipline is the end result of the various state Medical Boards. The boards grant license. They are also empowered to place those license on probation and to suspend and revoke those licenses. There are many problems that encumber state Boards in handling these problems. If the state Boards do not become more active and more aggressive in addressing the complaints of the public, we will see a Federal Licensing Board which is already in the thinking stage. The state Medical Boards, at the present time, may not be doing an adequate job but, I can assure you, if the responsibility for licensing and disciplining of physicians is taken over by the Federal Government, such as presently is being proposed, the public at large as well as the physicians have not seen problems such as this will bring.

There are more and more complaints coming to Medical Boards each year, and most of these come from consumers. The main complaint that comes to the State Medical Board in Arkansas revolves around the impaired physician, the incompetent physician and the abusive physician. The number that has been given in the past is approximately 1% to 2% of physicians fall within the classification of the incompetent or the drug abusing physician. This would indicate that we have some 6,000 to 12,000 physicians nationwide that fall within this category. The number is larger.

The impaired physician is much easier to determine than the substandard physician. They stand out among their colleagues much greater. Their families frequently will report them and patients are becoming extremely observant in regard to what may be an impaired physician.

The state Medical Boards are not alone in their failure to police physicians. Hospital Boards of Directors and Hospital Boards are a bit uneasy about sharing any sort of information with the state Medical Boards. It's amazing to see the way some Hospital Boards function. They're queasy and reluctant to report an incompetent or impaired physician, knowing that his license may be restricted in some manner. They seek to work out some type of agreement with the physician and usually end up asking him to get some continuing medical



education. They work at any method to get the physician off of their staff as opposed to any type of disciplinary action. I read recently where one hospital staff paid off a doctor's mortgage just to get him to resign from the staff.

Some Boards have the philosophy that discipline is the way of dealing with the physician. Other Boards are more lenient and feel that rehabilitation is the method of handling the problem, and others feel that there is a fine line that can be drawn by utilizing both methods. I'm of the opinion that it is possible to become too involved in the rehabilitative process and overlook the significant and severe problems.

A physician forfeits his right to continue to practice medicine when he abuses the system with alcohol and other forms of drugs and refuses to keep himself competent with continuing medical education. If physicians are not properly disciplined, this will continue to bring criticism. Most Boards are more interested in protecting the physician than they are protecting the public. In defense, to some degree, of the state Medical Boards, many states have laws that hinder and shackle the Board in its effort to take action against a physician because of the long litigation process.

State Medical Boards can only do their duty if complaints are made, if incompetent physicians are recognized and if impaired physicians are brought to the attention of the Board. Certainly, the physician's peers are frequently aware of the problem before they surface at other levels and we, as physicians, have long been reluctant to take a stand against a physician that we know is impaired or who, in some manner, is incompetent, just as we have been reluctant to testify against a physician that we well knew had maimed a patient because of his incompetence. This is a criticism that the public has leveled at us and it is due and just.

We, of the medical profession today, are living in the greatest technological age for the practice of medicine that has ever been known. As a result of this technology, we have lost the compassionate, humanistic attitude that physicians of 50 years ago exhibited. As technology improved, we began to lose the skill of applying the art of medicine. We don't seem to have the time to sit and speak with patients. We've forgotten to spend time discussing with the family their concerns and fears.

The materialistic side of the physician is so evident in that we must amass things and we must amass them rapidly so that we can enjoy them. The public is well aware that the physician has to belong to the best country club. It is absolutely necessary that he live in the largest home in the city, that he drive the finest automobile. The materialistic attitude of the physician who desires to take less responsibility has helped with that tarnished image. We seem to measure success on the one that survives with the most toys.



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I have touched upon a few problems that have changed our image in the eyes of the patients and the public over the past few years, and some of the things I perceive may have been responsible for this decline in esteem. The litany of charges that could be added is long, but it is not too late to change and change we must.

When practitioners of medicine come to the realization that medicine is the servant and not the master, then will we return to our rightful place of medicine being a noble profession.

# Superficial Cervical Block for Cervical Node Biopsy in a Child with a Large Mediastinal Mass

R. Charles Brownlow, M.D.\*

Jeffrey Berman, M.D.\*\*

Raeford E. Brown, Jr., M.D.\*\*\*

## SUMMARY

In patients with mediastinal masses, regional anaesthesia may be used for peripheral procedures. We have found the superficial cervical plexus block, when used with midazolam as an amnestic and anxiolytic agent, to be safe, reliable and well-tolerated alternative to general anaesthesia in pediatric patients with mediastinal masses.

Key words: anaesthetics, local  
anaesthesia, regional  
lymph node excision  
mediastinal

## INTRODUCTION

Catastrophic events associated with general anaesthesia in patients with mediastinal masses are well documented.<sup>1-4</sup> These events are usually associated with compression or obstruction of the airway, superior vena cava, or of the heart itself. These patients may be sensitive to changes in position, smooth muscle tone and cardiac filling pressures. General anaesthesia, especially associated with muscle relaxation, may produce static or dynamic airway obstruction or cardiac arrest. Patients with mediastinal masses may require peripheral diagnostic procedures in which general anaesthesia is not necessary. Regional anaesthesia with sedation offers an alternative to general anaesthesia in these patients. We report a case in which a superficial cervical

block was used to provide intraoperative anaesthesia for a supraclavicular node biopsy in a pediatric patient with suspected Hodgkin's lymphoma.

## CASE REPORT

The patient was an 11-year-old, 50-kg white female with a three-week history of decreased appetite, ten-pound weight loss, increasing fatigue and low-grade fever refractory to multiple antibiotic regimens. Chest x-ray revealed a large peri-hilar mass encasing but not deforming the trachea and mainstem bronchi. The patient denied shortness of breath, dyspnea on exertion, orthopnea, swelling or edema in her face or upper extremities. The patient was a mature and mildly obese white female. She had equal and symmetrical pulses, no jugular venous distention or pulses paradoxus, clear lung fields and no change in respiratory pattern or comfort when sitting or lying down. Heart sounds were normal with a regular rate and rhythm and no murmurs. Informed consent was obtained from the parents and patient and a peripheral intravenous line was placed in the holding room. The patient was then taken to the operating room where she was placed in a semi-Fowler's position with routine monitors. Glycopyrrolate (0.02 mg/kg) was given as an antisialogogue and midazolam was administered. A superficial cervical block was performed with 1% lidocaine and 1:200,000 epinephrine using a 23-gauge, 2-inch needle on a 10-cc syringe. A total of 20 cc of local anaesthetic was deposited along the posterior border of the right sternocleidomastoid muscle from the angle of the jaw to the clavicle and along the superior border of the clavicle from the midclavicle to the suprasternal notch. The patient was uncomfortable during the block but cooperated for its placement. After sedation with midazolam, and with the patient spontaneously ventilating and awake, the surgical prep and draping proceeded while the patient was informed of all potential aspects of the procedure. Verbal contact was maintained

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with the patient to distract her from the surgery and help evaluate her level of consciousness and mood. The patient experienced no discomfort during the surgery even with the supraclavicular dissection. Postoperatively the patient required no additional pain medications for the first three hours. She also had no memory of the placement of the block or the surgery.

Intraoperatively, a superclavicular lymph node was excised, which was determined to be Hodgkin's lymphoma on pathological examination.

## DISCUSSION

Providing anaesthetic management for pediatric patients with large mediastinal masses can be challenging. Numerous case reports document the potential for airway and cardiovascular compromise even in asymptomatic patients. Pediatric patients provide the additional challenge of requiring general anaesthesia or heavy sedation in order to obtain cooperation for even the most benign procedure. We were fortunate that our patient had a peripheral procedure amenable to a regional technique and that she was mature and tolerated the placement of a regional block as well as the intimidating surgical setting with minimal sedation. The preoperative assessment for patients with mediastinal masses is important regardless of a plan for general or regional anaesthesia. Evidence of cardiorespiratory compromise, especially with changes in position, sleep or exercise may provide useful information during the surgical procedure. This patient exhibited no dyspnea on exertion, shortness of breath or paroxysmal nocturnal dyspnea. She had no edema in her upper or lower extremities and had clear lung fields despite a large mediastinal mass visible on chest x-ray.

Because of her lack of symptomatology or physical evidence of cardiopulmonary compromise, we felt it safe to proceed with a regional technique with minimal sedation rather than with a general anaesthetic. The superficial cervical plexus block, which is often used to provide intraoperative anaesthesia for patients requiring carotid endarterectomy, is commonly used in our institution. We find it to be reliable, technically easy and associated with a low incidence of complications. Most texts describe a less extensive block, limiting it to a deposition of anaesthetic along middle third of posterior border of the sternocleidomastoid.<sup>5-7</sup> It is an institutional bias that we deposit local anaesthetic along the entire border of the sternocleidomastoid and medial half of the clavicle to block potential sensory fibers from the facial nerve and high intercostals. Our patient tolerated the placement of this block well and was pain-free during the surgery as well as during the immediate postoperative period. One percent lidocaine with 1:200,000 epinephrine and 0.1 mEq/mml sodium bicarbonate provided a safe local anaesthetic with a rapid onset and adequate duration. For longer surgical pro-

cedures, 1.5% lidocaine or 0.5% bupivacaine may be substituted. Sodium bicarbonate was added to reduce the pain of infiltration and to insure a quicker onset of the block. The controlled titration of midazolam provided a very cooperative, relaxed adolescent who was alert and responsive and had a normal respiratory pattern. The retrograde amnesia produced by midazolam for placement of the block and the surgical procedure was also considered a salutary effect.

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### CONVENTION "LINE-UP"

#### Thursday, April 7, 1994

- 8:30 a.m. Golf Tournament
- 1:00 p.m. Registration Opens
- 2:00 p.m. Council Meeting
- 3:30 p.m. Exhibits Open/Welcome Reception
- 5:00 p.m. House of Delegates
- 6:30 p.m. Blue Cross Blue Shield Reception

#### Friday, April 8, 1994

- 7:30 a.m. Council Meeting
- 8:30 a.m. Exhibits Open (Breakfast served)
- 11:00 a.m. First Session Speaker
- 12:30 p.m. Shuffield Lecture/Luncheon
- 2:15 p.m. Second Session Speaker
- 3:30 p.m. Exhibits Open (Refreshments)
- 6:30 p.m. "Take Me Out to the Ballgame" Party

#### Saturday, April 9, 1994

- 7:30 a.m. Council Meeting
- 8:00 a.m. Early Morning Refreshments
- 8:45 a.m. Third Session Speaker
- 10:30 a.m. House of Delegates
- 12:00 p.m. Fifty Year Club Luncheon
- 12:30 p.m. Specialties/Committees can elect to meet
- 6:00 p.m. Hospitality Hour
- 7:00 p.m. Inaugural Banquet
- 9:00 p.m. President's Dessert Reception

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# Botulinum Toxin in the Treatment of Adductor Spasmodic Dysphonia

*From the Voice Disorders Clinic, University of Arkansas For Medical Sciences*

A. Reed Thompson, M.D.\*

## ABSTRACT

Spasmodic dysphonia (SD) is a voice disorder that causes marked disability in the affected individual because of the severe disruption of normal communication that the disorder creates. Of the two distinct types, adductor and abductor SD, the adductor type is the most common and the most amenable to treatment. It is felt to be a neurological problem, but the specific lesion has not been found. The best treatment for adductor SD is injection of botulinum toxin into the thyroarytenoid muscles of the larynx.

## INTRODUCTION

Spasmodic dysphonia (SD) is a voice disorder characterized by strain-strangled phonation. It is often associated with irregular adductor or abductor spasms of the vocal folds so that the flow of speech is interrupted or "squeezed" making it difficult to understand. This communication disorder causes considerable distress in the individual affected because speech production is so effortful. Although the severity of the disorder varies, many patients with it become functionally disabled because of the interruption of normal communication. Two variants of the disorder have been described. Adductor spasmodic dysphonia is the most common. It creates the speech pattern described above. The other variant of the disorder effects the abductor muscles. These patients initiate phonation normally, but they are unable to sustain glottal closure and a weak, breathy phonation results. This type is abductor spasmodic dysphonia.

The cause of SD is unknown, but it apparently is a neurological disorder, being one of the types of a more general neurological disorder called dystonia. Primary

dystonias are typically action induced muscular disorders, in that the affected body parts appear perfectly normal at rest; but when use of that muscle group is initiated, strained muscle contractions occur causing twisting and abnormal postures that are usually sustained, but may be intermittent. The most common types are blepharospasm; spasmodic torticollis; writer's cramp, an action induced contraction of hand muscles with writing; and spasmodic dysphonia or focal laryngeal dystonia, effecting the vocal fold musculature. Multiple dystonias occurring simultaneously in a single patient are common.

Onset of SD can be at any age, but it is most commonly seen in the 5th and 6th decades. Males and females are effected equally. The overall incidence of the disorder is not known. Blitzer and Brin<sup>1</sup> speculate that there are approximately 100,000 patients with dystonia in the United States. Arkansas, having 1% of the population of the United States, would have approximately 1,000 patients with some variant of dystonia, several hundred of which would have SD.

## HISTORY

The disorder was first reported in the medical literature by Traube<sup>2</sup> in 1871. He coined the term spastic dysphonia. He felt that the disorder was of psychogenic origin. That idea persisted for the next 100 years when it became more obvious that the disorder was one arising in the neurological system. Gerhardt<sup>3</sup> in 1896 reported a group of patients with multiple dystonias, all of which had SD as part of the clinical presentation. Gowers<sup>4</sup> in 1899 first described the adductor and abductor types of the disorder. Primarily through the work of Aronson<sup>5</sup> beginning in the 1960s, a more thorough knowledge of the pathophysiology of SD has developed. His work set the stage for a remarkable increase in interest in he problem, both in research and treatment. Blitzer<sup>6</sup> in 1985 reported on electromy-

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graphic recordings from the vocal fold muscles in patients with SD, and Schaefer<sup>7</sup> in 1987 was the first to actually find various electrophysiologic abnormalities in the brain and brainstem of patients with SD. However, as yet no specific neurological lesion in the central nervous system has been linked to SD.

## DIAGNOSIS

The diagnosis of the disorder is primarily made on the clinical impression of experienced clinicians. There is as yet no method for confirming a positive diagnosis. However, spectrographic and electromyographic studies make significant contributions to diagnosis. A team approach to the diagnosis has proved to be most beneficial. Patients are seen by a speech/language pathologist and a laryngologist. A neurology referral is made when multiple dystonias or other neurological disorders are present or suspected. The diagnosis can be quite easy; but because SD varies so widely in presentation, the diagnosis also can be quite difficult. Primary care physicians are usually the first to see patients with the disorder, but occasionally patients get into the health care system through initial contact with a speech/language pathologist. The differential diagnosis includes benign essential vocal tremor, muscle tension dysphonias, amyotrophic lateral sclerosis, Parkinson's Disease and psychogenic dysphonias. As more data from research is accumulated, workers in the field now realize that the incidence of psychogenic dysphonias is much lower than initially thought, and many patients initially diagnosed as having a psychogenic dysphonia actually have SD.

## TREATMENT

In the first 100 years of literature on SD, psychotherapy was the recommended treatment. The disorder was felt to be psychogenic in nature for primarily three reasons: the severity of the disorder can vary from phrase to phrase, hour to hour, and day to day; no other neurological signs or symptoms were seen; and onset of vocal symptoms was noted frequently to occur with a stressful event in the patient's life. Psychotherapy has never been shown to correct the disorder. However, because patients can frequently become so disabled from the disorder, psychotherapy or counseling can be useful in developing coping strategies.

The speech/language pathologist plays an essential role in both the diagnosis and treatment. Although speech therapy does not offer cures, it does help patients identify and eliminate negative compensatory vocal behaviors that frequently develop in SD patients. Patient education and communication coping skills are typically part of a speech therapy program.

Antispasmodic medications have been recommended, notably baclofen; however, medications usu-

ally fail and side effects preclude their use.

Surgery for the disorder was first recommended by Dedo<sup>8</sup> in the early 1970s. He reasoned that since the disorder was primarily a neurological one, that sectioning the nerve supply to one side of the larynx should relieve the symptoms. He reported a series in which he sectioned one recurrent laryngeal nerve with a dramatic resolution of symptoms. However, follow up found a high failure rate with recurrence of symptoms in 65 to 70 percent of patients within 18 months to 2 years. Ludlow<sup>9</sup> and Blitzer<sup>10</sup> reported success treating adductor SD by injecting botulinum toxin directly into the vocal fold. Others have duplicated their results.

The current recommended treatment is direct injection of botulinum toxin (Botox) into the thyroarytenoid muscles of the larynx. Botox is purified type A botulinum toxin that is commercially produced from the microorganism *Clostridium botulinum*. Botox is chemically a polypeptide that blocks the secretion of acetylcholine at the myoneural junction. The blockade is apparently permanent; however within a few months new fibers sprout at the myoneural junction, allowing nerve conduction to proceed into the muscle, resulting in recurrence of symptoms. The success rate with injection is quite high, being reported around 90%. The resulting perceptual voice quality varies from slightly improved to significantly improved. Some patients whose perceptual voice quality is only mildly improved report a significant decrease in the effortfulness of voice production. The duration of symptom relief varies from two months to six months or longer with the average period of symptom improvement being four months. Therefore, injections must be repeated for an indefinite period in order to maintain satisfactory results.

Complications from the injection are minor. The patient may experience a very breathy voice for one to two weeks following the injection. A transient problem of mild aspiration, lasting a few days, is reported by a low percentage of patients. Patients are taught compensatory swallowing strategies pre-injection.

There are two techniques for the injection. One is done transorally under direct vision with topical anesthesia. The other method, used in the Voice Disorders Clinic at the University of Arkansas for Medical Sciences, is percutaneous injection directly into the thyroarytenoid muscle on each side of the larynx using electromyographic control. A muscular paresis develops, not a paralysis, reducing the intensity of the abnormal adductor spasms. The technique was initially done by Blitzer<sup>10</sup> in 1984. Injections have been done across the country in selected centers for the last eight years. No harmful effects, local or systemic, from injection of botox into the larynx have been reported.



## SUMMARY

SD is a focal laryngeal dystonia. The specific neurological lesion is yet to be identified. At present there is no cure for the disorder; but with the combination of speech therapy and botulinum toxin injections, patients can be helped significantly. Injection of botulinum toxin directly into the thyroarytenoid muscles of patients with adductor spasmodic dysphonia is a safe technique for the treatment of this disabling communication disorder.

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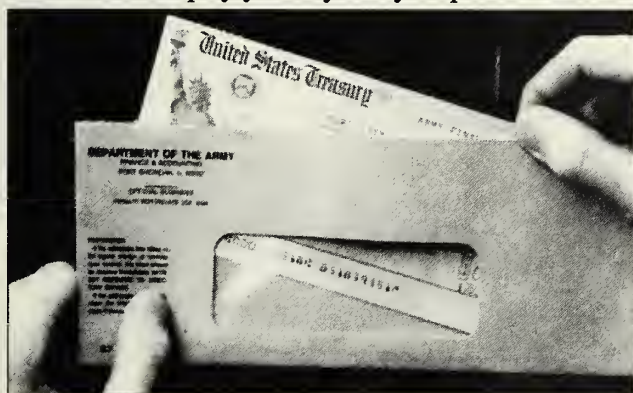
## ACKNOWLEDGEMENTS

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Ms. Kathy Forrest for the preparation of the manuscript.

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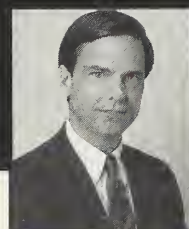
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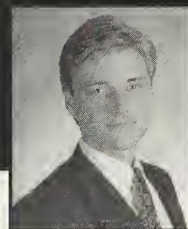
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**James R. Coffield**  
Vice President-Investments



**Todd Smurl**  
Financial Advisor

## Health Care Stocks: Good Medicine for Your Portfolio?

Investors trying to assess the impact of health care reform should take a careful look at what managed care will mean to the health care industry. Regardless of where the mandate for reform comes from - Washington or the States - the objective will be the same: to get more and more people into managed care plans, particularly HMOs. One possible outcome of this shift toward managed care plans would be an increased use of pharmaceuticals.<sup>1</sup>

For a drug company to do well under an expanded system of managed care, it will have to sell to as many HMO/PPO networks as possible, allowing for sales increases with a smaller, less expensive sales force. To do this, companies will need a good pipeline of breakthrough products that managed care companies must put on formularies.

As a group, drug stocks have underperformed the market so far in 1993, following a full year of underperformance in 1992. The pressures of health care cost containment have squeezed drug price flexibility, and constraints on utilization have slowed the groups rate of earnings growth. These factors should continue to slow growth, and the industry's new product pipeline is hardly overflowing. So are there any opportunities in this much maligned sector?

Absolutely! Many of you are aware of, and maybe some of you have participated in, the recent rally in the generic drug stocks. Although past performance is no guarantee of future results, in the first eleven months of 1993, Copley Pharmaceutical (CPLY 38 1/2) rose 59% and Zenith Laboratories (ZENL 66 1/2) rose 250%, and more recently Mylan Laboratories (MYL 25 3/4) stock has had a significant gain of over 20%. Since last winter, when the nation's politicians started talking about health care, the brand name drug stocks have taken a beating and the generic drug stocks have soared to unheard of heights.

Does that mean that we should join in the fun? Not necessarily. While it is true that generic drugs are

cheaper than equivalent brand-name drugs and that HMOs rightly insist on lower cost generics instead of branded drugs when substitution is possible, it does not mean that the generic drug industry is a successor or alternative to the branded drug industry. By law a branded drug can only become available in generic form after the 17 year patent protection expires. Because of this, many generics used today are drugs that were discovered decades ago.<sup>2</sup> For someone investing money today it would make very little sense to keep chasing this rally of generic drug stocks, when there are many more opportunities in the branded drug industry.

Even though the prognosis for the branded drug industry is for a sustained period of growth at or below historically average rates, because the industry is so fragmented, we expect some companies to be able to sustain double-digit earnings growth. Of course past performance is no guarantee of future returns, but several of these, Bristol-Myers Squibb (BMV 59 1/8), Merck & Co. (MRK 34 1/4), and Schering-Plough (SGP 66 1/8) seem to be attractively valued and likely to enjoy earnings growth rates of 10% to 12% annually.

Bristol-Myers Squibb has launched five prescription drugs in the past few years and should launch two more in the next three to six months. As a result, we expect pharmaceutical sales growth, which has been sluggish over the last 18 months, to accelerate beginning in the fourth quarter of 1993. Investors should expect for pretax operating income for BMV to rise at double-digit rates from that point forward.

Merck and Co. is the world's leading pharmaceutical company in virtually all respects. It has the most balanced product line, the best geographical representation, the deepest management, and the most productive research and in-licensing program in the industry. Merck is better positioned to handle cost containment pressures than other drug companies, the main reason being its breadth, size and patent position. Merck's product line encompasses more chronic-use therapeutic

tic categories with more successful drugs than any other company. Not only does Merck lead the United States in sales with roughly 9% of the market, but it is the leading American company in Europe and Japan, and Medco containment will only strengthen that position.

Schering-Plough Corp. is a large pharmaceutical company with diversified interests in animal health drugs and a variety of packaged consumer products. The company's consumer brands include Coppertone, Dr. Scholl's and Saint Joseph's.

Schering ranks about twentieth in terms of the size of its worldwide pharmaceutical operations. Its prescription drugs are concentrated in a limited group of therapeutic categories. Particular strength is in the respiratory sector, where the company's major products include Proventil for treating asthma and the non-sedating antihistamine Claritin. In the dermatological area, the company has long been a leader in topical steroids, and it has a strong position in topical antifungals, and it has a number of drugs pending approval by FDA and foreign regulators. As a potential merger partner, Schering might fetch a high price.

Sci-Med Life Systems is the second largest competitor in the global market for coronary angioplasty (PTCA) products. Sci-Med's recent acquisition of direct sales effort in the U.K. and Germany and local manufacturing capacity in Belgium should permit the assimilation of its strengths into the European market.

Earnings per share are projected to grow 15% to 17% annually over the next five years. Growth in PTCA-related sales (Angioplasty) should remain the primary driver, but forays into related fields could begin paying off in 1995.

Amgen is the largest biotech company in terms of market value, and is currently experiencing the highest earnings growth in the industry. It is a closely followed stock and has been a stellar performer owing largely to the success of Epogen, its flagship therapeutic

product for anemia in kidney dialysis patients, with other indications such as cancer soon to be pursued. Its second major product, Neupogen, is a white blood cell growth factor that promises to have widespread use as a means of stimulating depressed immune systems in patients undergoing cancer chemotherapy.

If you are a contrarian, it might make sense to invest in a diversified portfolio of drug stocks. Instead of putting all your eggs into one basket, you might wish to consider an equal dollar amount of the following stocks for that portion of your portfolio in which it would be considered suitable.

**Health Care Portfolio**

Bristol-Myers Squibb

Merck & Co.

Schering-Plough

Sci-Med Life Systems

Amgen

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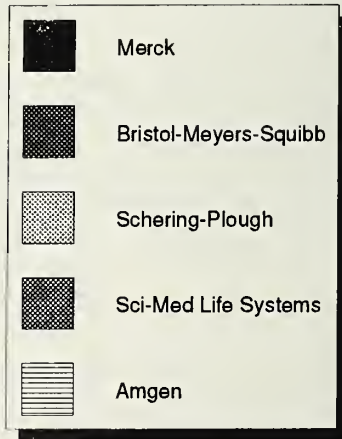
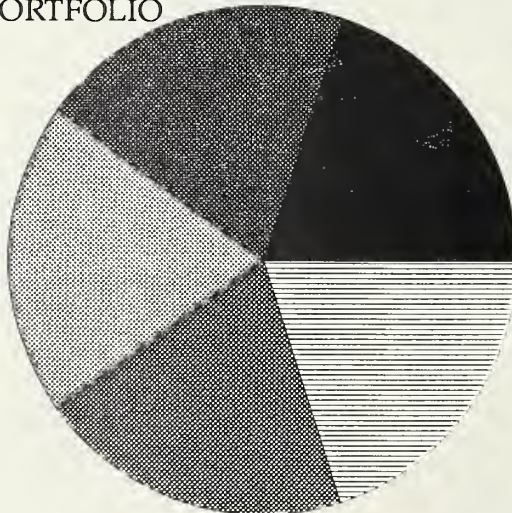
As always, consult with your financial advisor for suitability prior to making a decision of this magnitude.

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*Jim Coffield and Todd Smurl are Financial Advisors with the Little Rock office of Prudential Securities Incorporated. Any opinions expressed in this article are those of the authors, and not those of Prudential Securities.*

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# Minutes of the House of Delegates of the Arkansas Medical Society November 7, 1993

Speaker of the House John Crenshaw called the meeting to order at 1:30 p.m., Sunday, November 7, 1993, at the Camelot Hotel in Little Rock. Dr. Crenshaw announced this meeting as a special meeting to include members and nonmembers. Dr. Payton Kolb gave the invocation.

Dr. Crenshaw recognized two physicians in the audience: Dr. James Weber, president of the American Academy of Family Physicians and Dr. Patrick Maloney Chairman, Council of the American Academy of Physical Medicine and Rehabilitation and a director of the American Board of Physical Medicine and Rehabilitation. Also recognized but not in attendance were Dr. Betty Lowe, vice president and president-elect, American Academy of Pediatrics; Dr. John F. Redman, outgoing president, Southern Medical Association; Dr. Robert Barnes, American College of Surgeons Board of Governors and a member of the Executive Council, International Society for Cardiovascular Surgery - North America Chapter; and Dr. Joycelyn Elders, United States Surgeon General.

David Wroten, Assistant Executive Vice President, gave an update on the Department of Human Services lawsuit. Lynn Zeno, Director of Governmental Affairs, briefly discussed issues concerning health care reform.

Dr. Glen Baker explained the recent formation of a Managed Care Steering Committee and a feasibility study to determine, from industry and physicians in Arkansas, a level of interest of an Arkansas Medical Society sponsored managed care program. Dr. Baker introduced Bill Loweth, a consultant with Loweth Enterprises, Inc. of Houston, Texas, who explained the results of that study and the options the Medical Society might want to consider. His recommendation to the Arkansas Medical Society, as a result of the study, was to create a managed care management company which would promote and support a network of physicians and the formation of preferred provider organizations (PPOs) across the state.

Dr. Lloyd Langston, Founding Director of APPO in Pine Bluff, explained how their organization works with physicians, businesses, and hospitals in the area. Steve Lux of Florida Drum Company in Pine Bluff gave his views as an employer member of APPO.

After much discussion and upon motion by Dr. Glen Baker, the House of Delegates approved the following motions:

1) To accept the report of the consultant and authorize the Council of the Arkansas Medical Society to proceed with the development of a plan as recommended by the consultant.

2) The Arkansas Medical Society fund this program with initial capitalization of \$100,000 from reserves to be supplemented by physician assessments or membership fees of \$300 per physician, to be understood that if a critical mass of physician members is not received, funds or parts of those funds will be returned to those that made contributions.

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# House of Delegates - November 7, 1993

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Vice Speaker	Brenda Powell	present
President	Glen F. Baker	present
President-elect	James M. Kolb	present
Vice President	Gary L. Bevill	-
Secretary	Charles Rodgers	present
Treasurer	Lloyd Langston	present
Imm. P. Pres.	Larry Lawson	present
Chmn. Council	Charles Logan	present

## COUNCILORS

District 1	Don B. Vollman	present
	Dwight Williams	present
District 2	Lloyd Bess	present
	Michael Moody	present
District 3	Hoy Speer	present
	P. Vasudevan	-
District 4	Anna T. Ridling	-
	Paul Wallick	present
District 5	Wayne Elliott	present
	Robert Nunnally	present
District 6	James Armstrong	present
	John A. Gillean	present
District 7	Ronald Bracken	present
	Thomas Hollis	-
District 8	David Barclay	-
	Joseph Beck	present
	Paul Cornell	present
	William Jones	present
	Charles Logan	present
	R. Jerry Mann	present
	J. Mayne Parker	present
	Harold Purdy	present
District 9	Robert Langston	present
	David Rogers	present
	Janet Titus	present
District 10	Gerald Stolz	present
	Morton C. Wilson	present
	Paul Wills	-

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1971-1972	C. Stanley Applegate	-
1985-1986	John P. Burge	present
1983-1984	Asa A. Crow	present

1964-1965	C. Randolph Ellis	-
1969-1970	Ross E. Fowler	-
1951-1952	Charles R. Henry	-
1982-1983	Morriss M. Henry	present
1988-1989	John M. Hestir	present
1990-1991	William N. Jones	present
1987-1988	W. Ray Jouett	present
1976-1977	Albert S. Koenig, Jr.	-
1977-1978	W. Payton Kolb	present
1980-1981	Kemel E. Kutait	-
1986-1987	Ken Lilly	-
1967-1968	Joseph A. Norton	-
1974-1975	Ben N. Saltzman	present
1981-1982	Purcell Smith, Jr.	-
1968-1969	H. W. Thomas	-
1975-1976	T. E. Townsend	-
1963-1964	Joe Verser	-
1991-1992	George Warren	-
1972-1973	C. Robert Watson	-
1989-1990	James R. Weber	present
1984-1985	Charles F. Wilkins	-
1973-1974	John P. Wood	-
1978-1979	George F. Wynne	-

## DELEGATES

Arkansas (1)	Marilyn Speer	present
Ashley (1)	Luis Garcia	present
Baxter (2)	Robert Baker	present
	Peter MacKercher	present
Benton (3)	William Summerlin	-
	Tom Youngblood	present
Boone (1)	Carlton Chambers	present
Bradley (1)	Joe H. Wharton	present
Carroll (1)	Oliver Wallace	-
Chicot (1)	----	-
Clark (1)	Noland H. Hagood	-
Cleburne (1)	Lee Vaughn	-
Columbia (1)	Scott McMahan	-
Conway (1)	----	-
Craighead/ Poinsett (6)	R. Duke Jennings	-
	David Silas	-
	Joe Stallings	present
	Don Vollman	-
	Joe Wilson	-
Crawford (1)	----	-
Crittenden (1)	G. Edward Bryant	present
Cross (1)	----	-
Dallas (1)	Don Howard	-
Desha (1)	Howard R. Harris	-
Drew (1)	----	-



# House of Delegates - November 7, 1993

Faulkner (1)	----	-	C. Reid Henry	-
Franklin (1)	David Gibbons	-	Tom Jansen	-
Garland (5)	James Arthur	-	Anthony D. Johnson	present
	Naomal Jayasundera	present	Carl L. Johnson	-
	Gopakumar Maruthur	present	David King	present
	Robert McCrary	present	Marvin Leibovich	present
	Timothy Webb	-	Gail McCracken	-
Grant (1)	Clyde D. Paulk	-	Fred G. Nagel	present
Greene/Clay (1)	Albert Fonticiella	present	George A. Norton	-
Hempstead (1)	Lowell O. Harris	present	J. Mayne Parker	present
Hot Spring (1)	----	-	Carl J. Raque	present
Howard-Pike (1)	Joe King	-	John F. Redman	-
Independence (2)	William Waldrup	present	Ashley S. Ross	present
	John R. Baker	present	Ted Saer	present
Jackson (1)	M. A. Chauhan	present	Bruce E. Schratz	-
Jefferson (4)	Simmie Armstrong	-	Frank M. Sipes	-
	Sue Frigon	-	William L. Steele	-
	John Lytle	present	Robert G. Valentine, Jr.	-
	David Jacks	-	Samuel Welch	present
Johnson (1)	Richard E. McKelvey	-	John L. Wilson	present
Lafayette (1)	Sanford E. Hutson	present	Paul W. Zelnick	-
Lawrence (1)	Ralph Joseph	-	Albert Baltz	present
Lee (1)	Duong Ly	-	Mark Martindale	-
Little River (1)	Joe G. Shelton	-	Randy Ennen	-
Logan (1)	John R. Williams	-	R. Cole Goodman	-
Lonoke (1)	Jerry C. Chapman	-	David Kocher	-
Miller (3)	John A. Gillean	-	John R. Swicegood	present
	Joseph R. Robbins	present	William Schemel	-
	Herbert B. Wren	-	John J. Wikman	-
Mississippi (1)	Joe V. Jones	-	John D. Wells	-
Monroe (1)	N. C. David	-	Carl L. Williams	-
Nevada (1)	----	-	Mike Buffington	-
Ouachita (1)	Larry Braden	-	Sevier (1)	-
Phillips (1)	Francis Patton	present	St. Francis (1)	-
Polk (1)	Tom Tinnez	present	Tri-County (1)	present
Pope (2)	Don Riley	present	Union (2)	present
	Kevin Beavers	present	Van Buren (1)	present
Pulaski (32)	D. B. Allen	present	Washington (6)	----
	Raymond Biondo	present	White (2)	-
	Amail Chudy	present		Jim Citty
	Bob E. Cogburn	-		Daniel Davidson
	Claudia Davis	-	Woodruff (1)	-
	Phillip Deer, III	-	Yell (1)	-
	Kurt Dilday	-	Medical Student (1)	-
	Marlon Doucet	-	Resident (1)	----
	Jim English	present		-
	Charles P. Fitzgerald	-		-
	A. Tharp Gillespie	-		-
	William E. Golden	present		-
	Edwin Hankins, III	-		-
	Fred O. Henker	present		-

# 1993 Arkansas Medical Society Membership Roster Supplement

The following members of Ouachita, Phillips and Polk Counties were inadvertently left out of our 1993 Membership Roster printed in the December issue of *The Journal of the Arkansas Medical Society*. We apologize for any confusion this may have caused.

## **Ouachita County**

Braden, Lawrence F.  
Brunson, Milton  
Crump, Mark  
Dedman, J. L., Jr.  
Dedman, William D.  
Floss, Robert  
Fohn, Charles H.  
Guthrie, James  
Hout, Judson N.  
Jameson, John B., Jr.  
Kendall, Jerry R.  
Martin, Dan  
McFarland, Gale  
Miller, John H.  
Mosley, David  
Nunnally, Robert H.  
Ozment, L. V.  
Rayford, Cleveland  
Sanders, Cal R.  
Thorne, Arthur E.

## **Phillips County**

Athota, Prasad J.  
Barrow, John H., Jr.  
Bell, L. J. Patrick  
Bell, L. J. Patrick, II  
Berger, Alfred A.  
Epstein, S. Mitchell  
Faulkner, Henry N.  
Frederick, William Ronald  
Kirkman, C. M. T.  
McCarty, Charles P.  
McCarty, Gordon E., Jr.  
McDaniel, Marion A.  
Michel, Harry

Miller, Robert D., Jr.  
Nichols, Sandra D.  
Paine, William T.  
Patton, Francis M.  
Rangaswami, Narayanaswami  
Shah, Ashok C.  
Sorsby, Stephen  
Tan, Benjamin  
Tucek, Ladd  
Tukivakla, P. Reddy  
Vasudevan, Kanaka  
Vasudevan, P.  
Winston, William II  
Wise, James E., Jr.

## **Polk County**

Brown, David  
Finck, John Henry  
Fried, David D.  
George, Anthony D.  
Lochala, Richard  
McClard, Helen  
Mesko, John D.  
Rogers, Henry N.  
Sosa, Humberto J.  
Tinnesz, Thomas  
Wood, John P.  
Wynn, Chester



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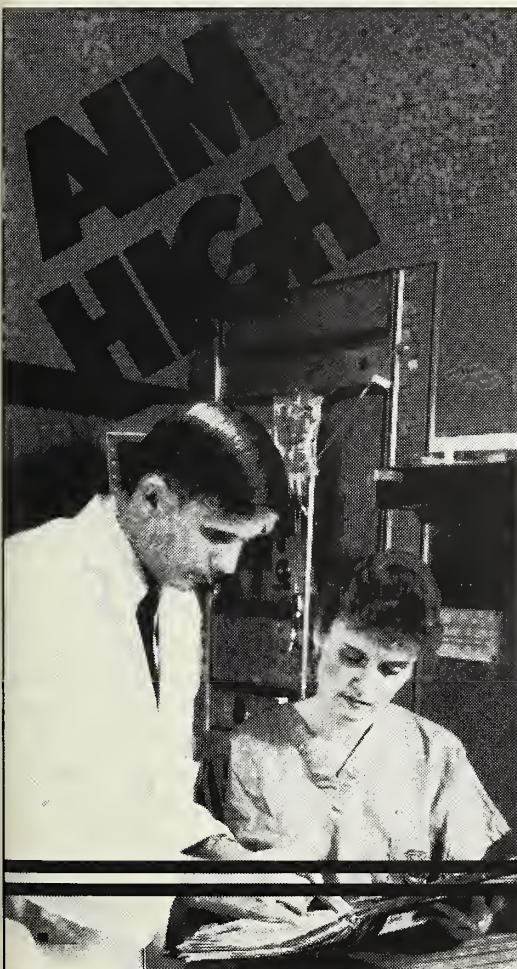
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# Outdoor MO

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## NEW BOATING ACCESS AREA OPENED ON SULPHUR RIVER NEAR FOUKE

Southwest Arkansas anglers and hunters have two new public boat ramps to provide access to the abundant hunting and fishing in the area, thanks to the cooperative efforts of private industry, officials in Miller and Nevada counties, the Arkansas Highway and Transportation Department and the Arkansas Game and Fish Commission.

The new Miller County access is on Sulphur River at Highway 71, eight miles south of Fouke. It provides access to the river itself and to the south end of the Commission's 16,543-acre Sulphur River Wildlife Management Area.

The 160-foot by 20-foot concrete ramp and gravel parking area were built by the Commission's construction crew at a cost of \$25,738 on land donated by the Arkansas Highway and Transportation Department.

The new Nevada County boat ramp is on the Little Missouri River at Nubbin Hill, off County Road 37 about eight miles north of Prescott. The 120-foot by 20-foot concrete ramp and graveled parking area sits on 1.22 acres of land donated by International Paper Company.

## LIFETIME LICENSE COULD PAY OFF IN LONG RUN

For the dedicated hunter a Lifetime Resident Hunting and Fishing Sportsman's Permit is available.

At \$1,000, the permit isn't a trivial investment, but it can be a real bargain if you're buying it for a young person. At 1993-94 license prices, a 16-year-old Arkansas resident who buys a Resident Combination Sportsman's License each year will spend a total of \$1,775 by age 65. Add in the state trout and state waterfowl stamps (which are also covered by the Lifetime Permit), and the cost rises to \$2,375. And this doesn't take into consideration any future license increases. A bonus is the price includes a lifetime subscription to Arkansas Wildlife magazine, currently priced at \$5 per year.

The Lifetime Resident Hunting and Fishing Sportsman's Permit can also be a bargain for those who are currently residents of the state but plan to move elsewhere. Holders of Lifetime Permits retain their Arkansas hunting and fishing privileges even if they move to another state after the purchase. With the current cost of non-resident licenses standing at \$150 and \$25 for hunting and fishing, respectively, a resident who buys a Lifetime Permit and then moves away from Arkansas will be ahead of the game after only six years.

For a Lifetime Resident Hunting and Fishing Sportsman's Permit application, contact the Game and Fish Commission's Licensing Section, 2 Natural Resources Drive, Little Rock, AR 72205, phone 223-6388. Or call 1-800-364-GAME and use a Visa or MasterCard.

## WATERFOWL REPORT BEGINS ON GAME AND FISH "HOT LINE"

Reports on waterfowl conditions around Arkansas, updated twice weekly, have started on the Arkansas Game and Fish Commission information "hot line".

To hear the reports, dial 688-8000 then, when asked, dial 4253. The line is accessible only with touch-tone phones, and the call is long distance outside the Little Rock area.

Several other "hotlines" supply other information about hunting, fishing and other outdoors topics. All are reached through the 688-8000 number. The access codes for each topic are:

- 4250 - big game seasons
- 4251 - small game seasons
- 4252 - fishing information
- 4254 - hunter and boater education
- 4255 - licensing information
- 4256 - water levels
- 4257 - shooting range information
- 4258 - boat registration information
- 4259 - current events

## BUY LICENSES ROUND-THE-CLOCK

Fishermen, hunters and vacationers planning trips to Arkansas can buy Arkansas Game and Fish Commission licenses by telephone from anywhere in the nation.

Any time of day licenses can be bought by calling 1-800-364-GAME and charging them to Visa and MasterCard. Sportsmen sometimes arrive in Arkansas when sporting goods stores and other license dealers are closed and can't buy licenses for an outing early the next morning. They can call the toll-free number, whether Arkansas residents or non-residents, give the required information plus their credit card number and receive a fishing or hunting license number immediately. The actual license will be mailed, but a wildlife officer can verify the number by telephone with an in-the-field radio call.





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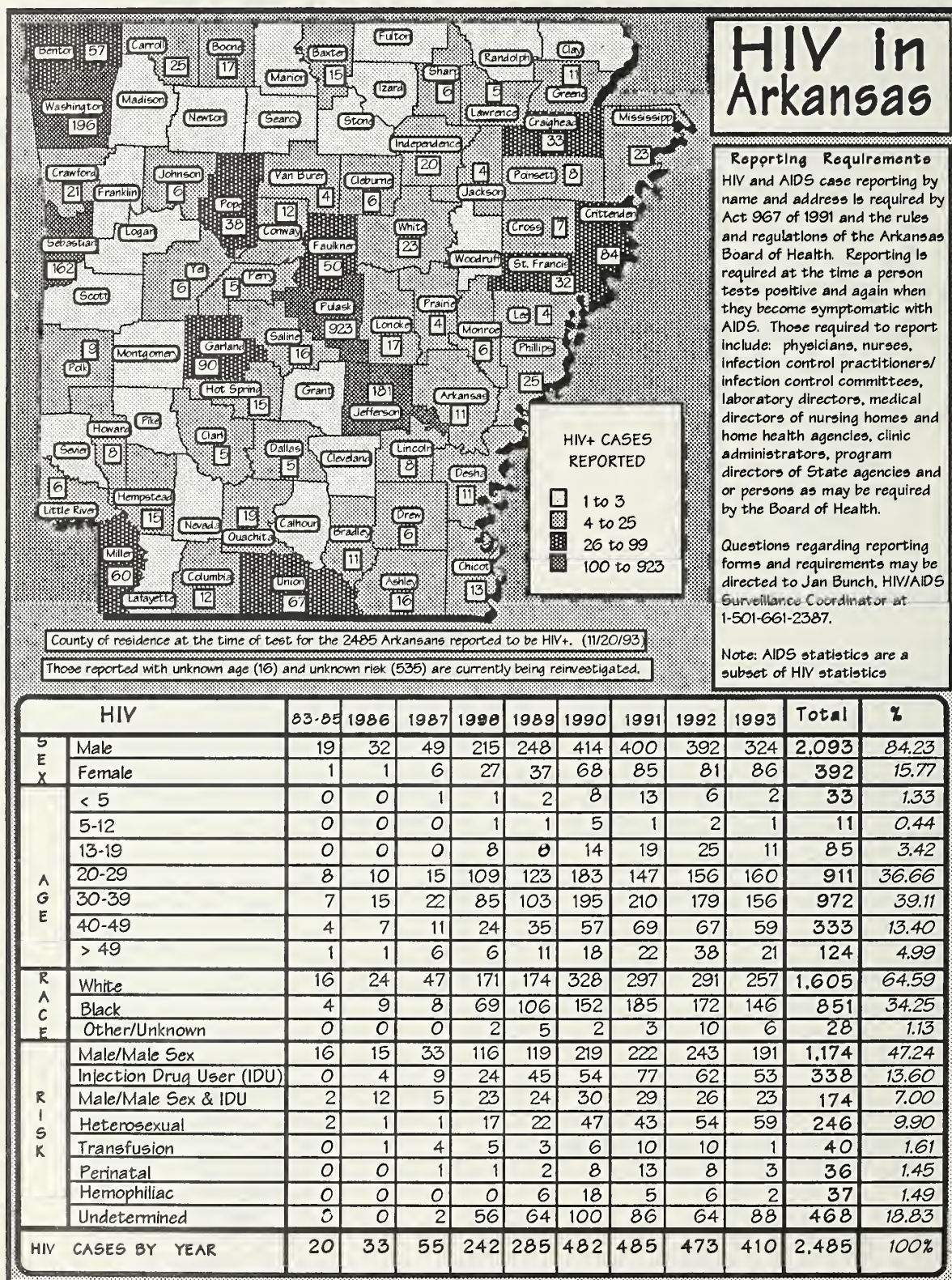
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# Arkansas HIV/AIDS Report

## 1983-1993

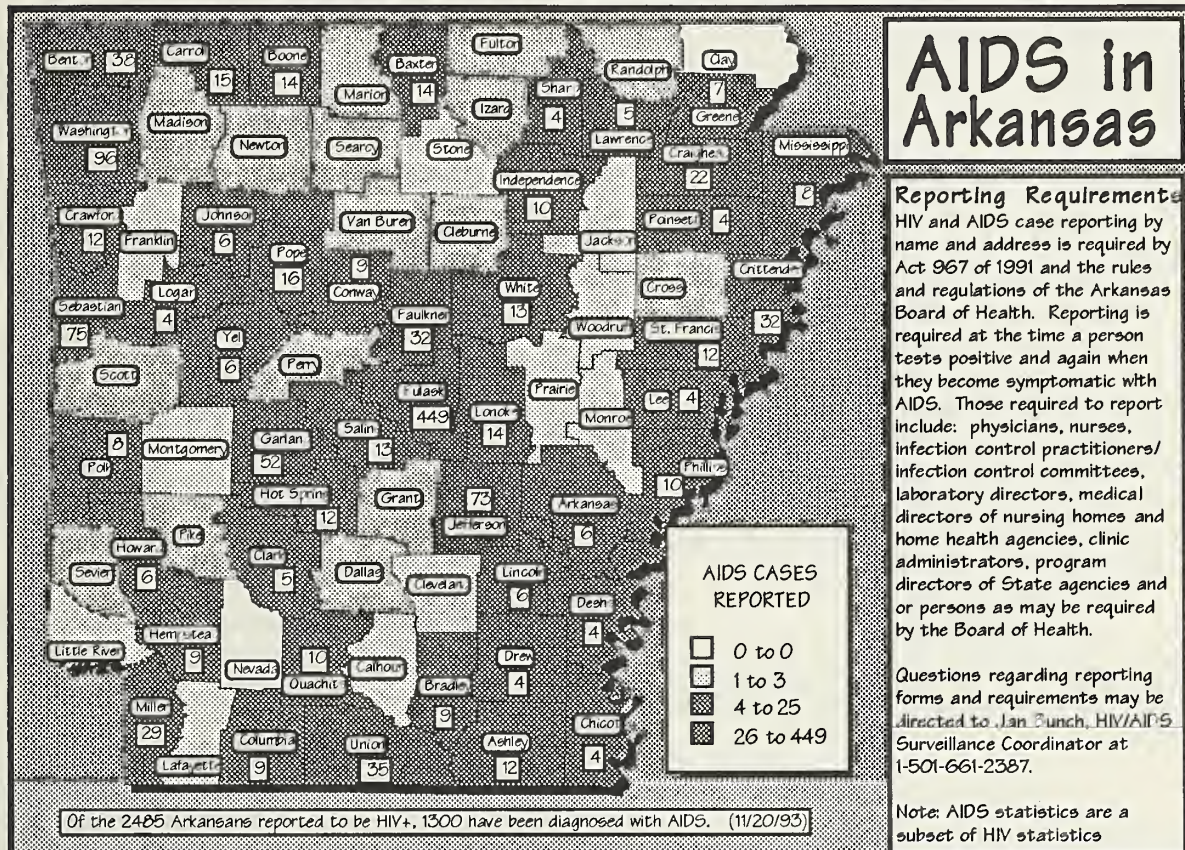


Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1993



AIDS		83-85	1986	1987	1988	1989	1990	1991	1992	1993	Total	%
SEX	Male	11	28	46	77	70	170	176	250	309	1,137	87.46
	Female	1	0	4	6	10	20	25	35	62	163	12.54
AGE	< 5	0	0	0	1	1	6	6	3	0	17	1.31
	5-12	0	0	0	1	0	1	1	0	1	4	0.31
	13-19	0	0	0	0	0	4	3	2	4	13	1.00
	20-29	7	9	15	27	24	55	57	81	101	376	28.92
	30-39	3	13	23	36	41	78	80	128	169	571	43.92
	40-49	1	6	8	10	7	35	41	52	71	231	17.77
	> 49	1	0	4	8	7	11	13	19	25	88	6.77
RACE	White	9	22	43	61	58	141	134	206	259	934	71.85
	Black	3	6	7	20	21	47	66	75	108	352	27.08
	Other/Unknown	0	0	0	2	1	2	1	4	4	14	1.08
RISK	Male/Male Sex	7	17	31	59	50	120	120	179	202	785	60.38
	Injection Drug User (IDU)	0	2	10	4	11	18	29	43	55	172	13.23
	Male/Male Sex & IDU	3	9	4	6	6	18	17	19	23	105	8.08
	Heterosexual	2	0	2	3	6	10	9	25	42	99	7.62
	Transfusion	0	0	2	7	3	7	11	3	2	35	2.69
	Perinatal	0	0	0	1	1	6	6	3	1	18	1.38
	Hemophiliac	0	0	0	1	1	5	5	4	5	21	1.62
	Undetermined	0	0	1	2	2	6	4	9	41	65	5.00
AIDS CASES BY YEAR		12	28	50	83	80	190	201	285	371	1,300	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# New Members

---

## ARKADELPHIA

**Elkins, John S.**, OB/GYN. Medical education, UAMS, 1980. Internship/Residency, St. Paul Hospital, Dallas, 1987. Board certified.

## ASHDOWN

**Swiney, Jennifer R.**, Internal Medicine. Medical education, University of Missouri Medical School, Columbia, 1973. Internship/Residency, St. John's Mercy Medical Center, 1978. Board certified.

## BERRYVILLE

**Warner, Milo N.**, General Surgery. Medical education, Kirksville College of Osteopathic Medicine, 1975. Internship, Warren General Hospital, Warren, Ohio, 1976. Residency, Pontiac Osteopathic Hospital, Pontiac, Michigan and Youngstown Osteopathic Hospital, Youngstown, Ohio, 1982. Board certified.

## CARLISLE

**Rochelle, Joe M.**, Family Practice. Medical education, UAMS, 1990. Internship/Residency, UAMS, 1993. Board certified.

## CONWAY

**Dodge, Ben M.**, Orthopedic Surgery. Medical education, UAMS, 1988. Internship/Residency, UAMS, 1993. Board eligible.

## FAYETTEVILLE

**Hargrove, Kevin W.**, Orthopaedic Surgery. Medical education, University of Oklahoma, Oklahoma City, 1987. Internship/Residency, University of Oklahoma Health Sciences, 1992. Board eligible.

**Moon, Steven L.**, Neurology. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1981. Internships, USAF Hospital, San Antonio, 1982, and University of Oklahoma, 1988. Residencies, University of Kansas Medical Center, 1985; University of Kentucky, 1987; University of Kansas Medical Center, 1991. Board certified.

## HELENA

**Shah, Ashok C.**, Internal Medicine. Medical education, Banda Medical College, India, 1979. Internship/Residency, Jamaica Hospital Medical Center, 1993.

## LITTLE ROCK

**Guard, Peggy K.**, OB/GYN. Medical education, University of Texas Health Science Center, 1986. Internship/Residency, St. Joseph Hospital, Houston, 1990. Board certified.

**Hart, Thomas M.**, Pain Management. Medical education, University of Texas Health Science Center, San Antonio, 1986. Internship/Residency, University of Texas Health Science Center and University of Missouri, 1990. Board certified.

**Kolb, David C.**, Emergency Medicine. Medical education, UAMS, 1987. Internship/Residency, Methodist Hospital, Memphis, 1989 and Charity Hospital/LSU Medical Center, 1992. Board pending.

**Parham, Groesbeck P.**, Gynecologic Oncology. Medical education, University of Alabama Medical Center, Birmingham, 1981. Internship/Residency, University of Alabama Medical Center, 1985. Board certified.

**Willis, Charlotte R.**, Pediatrics. Medical education, LSU, 1990. Internship/Residency, Arkansas Children's Hospital/UAMS, 1993. Board eligible.

## NEWPORT

**Snodgrass, Phillip A.**, General Surgery. Medical education, UAMS, 1964. Internship/Residency, Mobile General Hospital, 1972.

## PINE BLUFF

**Pollard, James A.**, Orthopaedic Surgery. Medical education, UAMS, 1988. Internship/Residency, University of Texas Medical Branch, Galveston, 1993. Board pending.

**Shah, Sailesh N.**, Cardiology. Medical education, G. S. Medical College, Bombay, India, 1982. Internship, Cook County Hospital, Chicago. Board certified.

## ROGERS

**Aguilar-Guzman, Orlando F.**, Urology. Medical education, Texas Tech University School of Medicine, Lubbock, 1981. Internship, St. Joseph Hospital, 1982. Residency, St. Joseph Hospital and UAMS, 1986. Board certified.

## SHERWOOD

**Collins, Kevin J.**, Physical Medicine & Rehabilitation. Medical education, University of Southern California School of Medicine, 1989. Internship, University of Cincinnati Medical Center, 1993. Board eligible.



## STAR CITY

**Whipple, Paul E.**, Family Practice. Medical education, University of New England, Biddeford, Maine, 1990. Internship, Cranston General Hospital, Cranston, R.I., 1991. Residency, Community Hospital of Rhode Island, Cranston, R.I., 1993. Board eligible.

## WALNUT RIDGE

**Kostick, Richard A.**, Radiology. Medical education, UMDNJ-New Jersey School of Osteopathic Medicine, 1986. Internship, Baptist Medical Center, 1987. Residency, Philadelphia College of Osteopathic Medicine, 1990. Fellowships, Mount Sinai Medical Center and Jackson Memorial Hospital, 1993.

## WEST MEMPHIS

**Peeples, Guy L.**, General Surgery. Medical education, University of Tennessee School of Medicine, 1986. Internship/Residency, University of South Alabama Hospital, 1993. Board eligible.

## RESIDENTS

**Coleman, Roy D.** Medical education, UAMS, 1993.

**Henry, William W., Jr.**, Family Practice. Medical education, UAMS, 1993. Residency, AHEC-Pine Bluff.

**Hill, Harold R.**, Family Practice. Medical education UAMS, 1993. Internship, AHEC-Pine Bluff/UAMS.

**Malone, K. Scott**, Physical Medicine & Rehabilitation. Medical education, East Tennessee State, Johnson City, 1992. Internship, East Tennessee State, 1993. Residency, UAMS.

**Neuwirth, Bryan R.**, Oral & Macillofacial Surgery / Cosmetic Surgery. Medical education, University of North Carolina, Chapel Hill, 1991. Internship/Residency, University of North Carolina, 1993.

**Pilkington, Neylon S.**, Pediatrics. Medical education, UAMS, 1993. Internship, UAMS/Arkansas Children's Hospital.

**Roper, Richard K.**, Family Practice. Medical education, UAMS, 1993. Internship/Residency, AHEC-South Arkansas, El Dorado.

**Zacker, Stephen P.**, Anesthesiology. Medical education, University of Oklahoma School of Medicine, Oklahoma City, 1993. Internship/Residency, UAMS.

## STUDENTS

Hayley M. Garner

Dina L. Horton

George S. Lawrence

Gregory D. Wood



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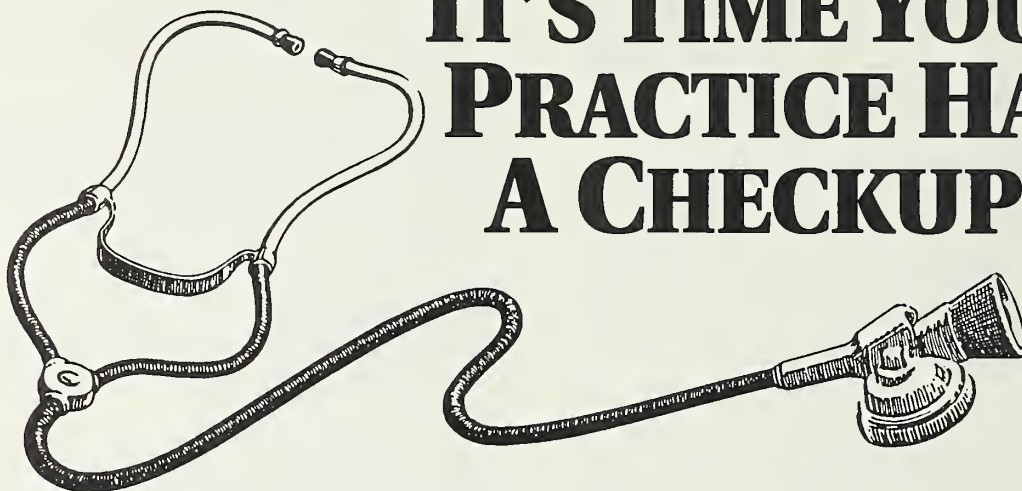
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| Would your practice's utility bills be paid?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would professional or trade dues be paid?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
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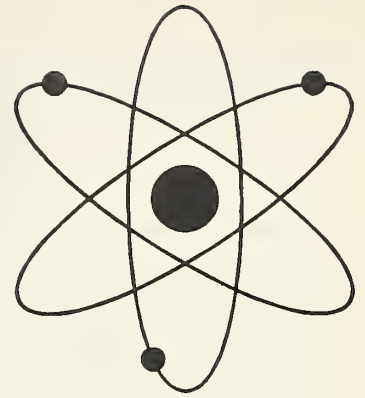
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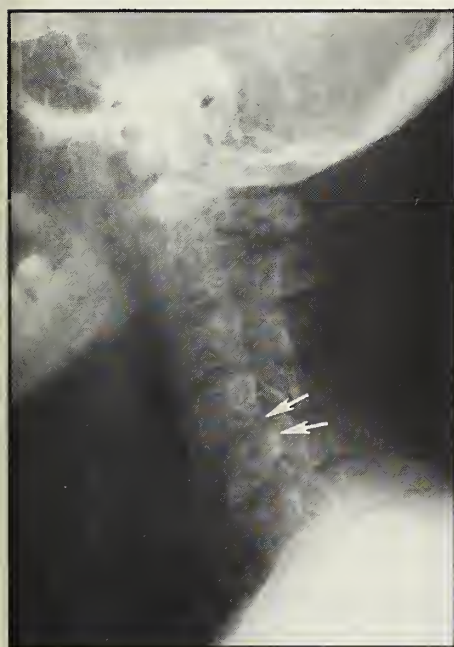
# Radiological Case of the Month



David L. Harshfield, M.D.  
Richard Jordan, M.D.  
Kelly Grigg, B.S.

## History:

The patient presented to the Emergency Room with history of a flexion-rotation injury as a result of a motor vehicle accident.



*Figure 1*



*Figure 2*



*Figure 3*

---

# A facet dislocation (perched or jumped facet) on the right at C4-C5.

---

## Findings:

(Figure 1) The lateral cervical spine study reveals a subtle anterior subluxation of C4 on C5 with interruption of the posterior spinal line and slight narrowing of the disc space. Degenerative changes at the C5-C6 disc space are noted.

(Figure 2) The AP cervical spine study reveals the spinous processes of C5, C6 and C7 to be midline. The spinous processes beginning at C4 and above are to the right of the midline.

(Figure 3) The right anterior oblique image reveals the neural foramen at the C4-C5 level to be asymmetric in comparison to the other neural foramina in the cervical spine. The normal neural foramina on this view are oval with the long axis directed vertically. At the C4-C5 level the neural foramen is oval with the long axis directed almost horizontally.

## Discussion:

The typical cervical spine series consists of five views. The lateral view is usually obtained in a cross-table lateral technique, and most significant pathology can be detected on this view. In a review of 420 cervical spine fractures, the lateral view was positive in over 90%.<sup>1</sup> In addition, an AP, both obliques, and an odontoid view should be obtained. If on these five standard views there is a suspicion (as in this patient) of an injury of the pillar or facet, a pillar view can be performed. The head must be turned for pillar views and, therefore, it must be deemed safe to move the patient prior to obtaining them. The only safe way to do this is for the patient to move their head only within the limits of pain. The technologist must never move the head without the patient's assistance for pillar views when a fracture is suspected. On the lateral view key points of interest include the following: the space between the odontoid and anterior ring of C1 should not exceed 2 mm in adults, the soft tissue space anterior to the inferior margin of C2 should not exceed 7 mm, and at C6 should not exceed 22 mm in adults.<sup>2</sup> On this patient the lateral view reveals subtle findings which were corroborated by the PA view, and the suspicion of a facet abnormality could be confirmed on the five standard views. One final point; a significant number of cervical spine fractures (50%) involve the posterior arch.<sup>3</sup> Therefore, one should maintain a high degree of suspicion for these types of injuries when viewing cervical spine studies.

## References

1. Gerlock AJ, Kirchner SG, Heller RM, et al. *The Cervical Spine in Trauma*. Philadelphia, W. B. Saunders Co., 1978.
2. Gehweiler JA, Osborne RL, Becker RF. *The Radiology of Vertebral Trauma*. Philadelphia, W. B. Saunders Co., 1980.
3. Harris JH. Acute injuries of the spine. *Semin. Roentgenol.* 13:53, 1978.

---

*Editor: Dr. David Harshfield is Chief, Radiology Service at the Veterans Administration Hospital in Little Rock, and Director of Radiology at Riverside Radiology Group in North Little Rock.*

*Contributor: Dr. Richard Jordan is a neurosurgeon in private practice in North Little Rock.*

*Contributor: Kelly Grigg is a premedical student research assistant at the University of Arkansas for Medical Sciences in Little Rock.*





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# AMS Newsmakers

---

**Dr. Walter Barnes, Jr.**, a general surgeon in Texarkana, recently received the 1993 C.E. Palmer Award at the Texarkana Chamber of Commerce's annual meeting. The award is the most prestigious honor given to a person for a lifetime dedication to the community.

**Dr. Jim L. English**, of Little Rock, a facial plastic surgeon and fellow of the American Academy of Facial Plastic and Reconstructive Surgery, has been installed as vice president of the organization's Southern region.

**Dr. Geoffrey Goldsmith**, chairman of the UAMS Department of Family and Community Medicine, will represent UAMS on the Bureau of Health Professions Rural Health Medical Education Program. He is the first Arkansan appointed to the program. The program is federally funded through the Health Resources Services Administration in the Public Health Administration. Goldsmith will serve as reviewer of grant applications for model primary care residency education programs linked with rural hospitals.

**Dr. Paul Haut**, chief resident of the Department of Pediatrics through the University of Arkansas for Medical Sciences at Arkansas Children's Hospital in Little Rock, has been elected chairman-elect of the Resident Section of the American Academy of Pediatrics.

**Dr. Morriss M. Henry** has recently published an article describing a new technique for use during cataract surgery in the current issue of "Ocular Surgery News." The article discusses his method of anesthetic placement around the eye which improves patient comfort and means that patients may need little or no sedation during the surgery. The article also explains Henry's use of a self-sealing "no stitch" incision which results in the eye healing more quickly.

**Dr. John Hestir** was recognized at the thirtieth anniversary of DeWitt City Hospital for his commitment and year of service to the hospital and the DeWitt area. Dr. Hestir admitted the first patient and delivered the first baby at DeWitt City Hospital.

**Dr. Carl L. Nelson**, chairman of the Department of Orthopaedics at the University of Arkansas for Medical Sciences in Little Rock, has been reappointed to the Board of Governors of the American College of Surgeons as a representative from the American Orthopaedic Association. He has also been elected na-

tional president of the Musculoskeletal Infection Society and is serving as program chairman for the 1994 meeting of the Mid-America Orthopaedic Association.

**Dr. Frank Panettiere**, a Rogers oncologist, is working on an international colon cancer research project coordinated by Oxford University in England. The focus of the project is to evaluate the long-term effects of treatment on cancer patients.

**Dr. D. Bluford Stough, III**, of Hot Springs received the William K. Wright Award at the annual meeting of the American Academy of Facial Plastic and Reconstructive Surgery. The award is given to a physician who has "made outstanding contributions to facial plastic and reconstructive surgery."

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## Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of September, October and November are:

Clark M. Baker	Springdale
James D. Billie	Little Rock
William B. Bishop	Little Rock
Dabney H. Brannon	Fayetteville
Jerry C. Chapman	Cabot
William C. Glover	Little Rock
Richard L. Hardcastle	Paragould
Edward P. Hammons	Forrest City
Michael B. Johnson	Little Rock
Kenneth B. Jones	Jonesboro
David J. Marzewski	Jonesboro
Paul R. Neis	Mountain Home
Norton A. Pope	Little Rock
Robert C. Power	Little Rock
Douglas F. Smart	Little Rock
Ronald D. Smith	Blytheville
Linda N. Teal	Mountain Home
Phillip L. White	Murfreesboro

*The American Medical Association does not maintain a central file of the reported Continuing Medical Education (CME) activities of physicians who have applied for the Physician's Recognition Award. No copy of the application is maintained in their file, which contains only the record that you have been awarded the PRA certificate and the date of the certificate. It is recommended that each physician maintain an individual file of continuing medical education activities and awards.*

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## **Arkansas Medical Society Alliance Announces AMA-ERF Scholarship Recipients for 1993-94**

The Arkansas Medical Society Alliance recognized eight medical students at the University of Arkansas College of Medicine with the American Medical Association Education and Research Foundation Scholarship for 1993-94. The county chapters of the Alliance contribute each year to a scholarship fund for deserving medical students. The AMA-ERF scholarships are awarded annually to medical students who demonstrate outstanding academic achievement and "possess the humanitarian skills to become caring and compassionate physicians". Through the fund-raising efforts of the county chapters, the Alliance has also funded many College of Medicine projects designed for teaching medical students. The number of scholarships awarded has increased over the years, from one in 1988 to eight in 1993. Presentation of the awards was made at the annual College of Medicine Scholarship Banquet. The Alliance was represented by Mrs. Linda Goldsmith, the AMA-ERF Scholarship Chairperson for 1993-94. Pictured left to right: Robert Boswell of Little Rock; Gary Go of Little Rock; Yolanda Lawson of Malvern; Elise Fortin of Russellville; Mrs. Linda Goldsmith, Arkansas Medical Society Alliance; Judith Bynum of Dermott; Shelley Russell of Nashville; Wade Ceola of Tontitown; and John Lazenby of Little Rock.

## **AIDS Agency Receives Check From Elizabeth Taylor AIDS Foundations**

Steve Land, director of client services at Northeast Arkansas Regional AIDS Network, and Louis Vennell III wrote an application to Elizabeth Taylor AIDS Foundations and received \$10,000 to help people with HIV/AIDS.

Vennell said he sent a packet of information to the Elizabeth Taylor AIDS Foundations after receiving guidelines for funding. He says the money will be used for a buddy program for local victims of the disease.

Through the buddy program, trained volunteers will be friends and helpers to people with HIV/AIDS. Vennell said the program will be modeled after the AIDS Coalition in New Jersey, where he is from. The funding will be used for training volunteers and for activities for clients and buddies.

Vennell said the program will be established as a pilot program in Batesville and Jonesboro. It will involve a third of the agency's 136 clients. Members of the NARAN staff will be the first buddies trained.

## **Medicare Fee Schedules Available**

The proposed Medicare Fee Schedules For Physicians services for calendar year 1994 were recently released in the Thursday, December 2nd Federal Register. Copies of this publication are now available from the Birmingham Government Printing Office Bookstore. Paper copies are priced at \$4.50. Computer diskettes are also available for \$17. Prepayment is required when ordering. Orders can also be accepted by phone using a Visa or MasterCard. Checks must be made payable to Superintendent of Documents and mailed to:

Birmingham GPO Bookstore  
2021 Third Ave. N.  
Birmingham, AL 35203

Phone orders can be made by calling (205) 731-1056 between the hours of 9 a.m. and 4:30 p.m., Mon-Fri. Checks should be made for the exact amount of purchase as no tax or mailing fees are charged.

## **In Memoriam**

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### **Hugh R. Edwards, M.D.**

Dr. Hugh R. Edwards, of Searcy, died Thursday, December 2, 1993. He was 79.

Survivors are his wife, Geneva H. Edwards; two children, Marcia Darr of Little Rock and Robert Edwards of Searcy; four grandchildren, Ashley Henry, Catherine Henry, Reed Edwards and Mario Edwards; two brothers, James Edwards of Batesville and Charles Edwards of Conway.

# Residents Respond to AMS Survey



In October, 1993, the Arkansas Medical Society conducted a survey to help determine ways the AMS could meet the special needs of its resident physician members. Of the 444 members of the AMS Resident Physician Section, 25% responded to the survey. Nineteen medical specialties were represented by the respondents.

To find out what issues residents were most concerned with, the survey included a question about attending seminars. By far, the most important issues identified related to what comes after residency: joining a partnership or group practice, the business side of medicine, how to start a practice and computers.

Interestingly, legislative issues and PPO/HMO's were identified by less than 50% of the respondents. Given the current environment of medical practice and the national attention on health system reform, we expected more interest in these areas.

One particular avenue where the AMS has been able to provide valuable information for medical students is through luncheon meetings at UAMS. Two or three times each semester, the Society sponsors a luncheon for students. Each time a speaker discusses various issues such as malpractice, legislation, AIDS and other topics not usually covered in medical school. Attendance at the meetings averages 75 students.

We asked residents about doing a similar program and received very high support. Eighty-two percent of respondents indicated interest in attending a noon luncheon held at UAMS. Although, no particular day of the week received a majority of votes, Wednesday and Friday were the most favored days.

Social activities are an important part of everyone's life. The AMS provides physicians several opportunities each year to network and socialize with colleagues. We asked residents about attending evening receptions and family-oriented events. While residents were split on attending a family-oriented event, over 70% indicated an interest in attending an evening reception.

The information gained from this survey may seem somewhat simple and matter-of-fact. However, because of the multitude of residency programs, each with their own scheduling system and responsibilities, planning

becomes quite a challenge. Minor issues such as what day to have a meeting become major factors in determining what services or activities we should concentrate on when allocating resources.

The information provided by this survey will help the AMS leadership to better meet the needs of resident members. Activities and benefits can be developed which focus on the major concerns of residents while respecting the limited amount of time residents have available to be involved outside of their clinical responsibilities.

If you would like more information on the AMS Resident Physician Section, contact Laura Harrison, Special Projects Coordinator, at the AMS headquarters office in Little Rock.

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# Things To Come

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## February 1-4

**HIV/AIDS and the Primary Care Practitioner - You CAN Make a Difference.** Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Category I credit: 15 hours. For more information, call (916) 734-5390.

## February 1-5

**19th Annual Meeting of the Alliance for CME.** Hotel del Coronado, San Diego, California. For more information, call Daniel E. Reichard, George Washington University Medical Center, (202) 994-4285.

## February 4-5

**12th Annual Infectious Disease Conference.** Hilton Hotel, Sacramento, Calif. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Category I credit: 11 hours. For more information, call (916) 734-5390.

## February 5

**Otolaryngology for the Primary Care Physician.** Hotel Intercontinental, New Orleans. Sponsored by the Tulane University Medical Center. Category I credit: 8 hours. For more information, call (504) 588-5466 or (800) 588-5300.

## February 11-12

**Incontinence Update.** Hyatt Regency Hotel at the Louisiana Superdome, New Orleans. Sponsored by the Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## February 14-16

**HMOManaged Care Policy Conference.** The Washington Hilton and Towers, Washington, D.C. Sponsored by the Group Health Association of America, Inc. For more information, call (800) 347-8074.

## February 18-20

**American Academy of Pain Medicine 1994 Annual Refresher Course and Conference.** Buena Vista Palace, Orlando, Florida. For information call Cathy Crabbe, (708) 966-9510.

## February 19

**Trends in Healthcare: The Adult Diabetic.** Windsor Court, New Orleans. Sponsored by the Tulane University

Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## February 20-25

**Emergency Medicine 1994: 17th Annual UCD Winter Conference.** Hyatt Regency Lake Tahoe, Incline Village, Nevada. Sponsored by the Tulane University Medical Center. For more information, call (916) 734-5390.

## February 26

**Cardiology for the Primary Care Physician.** Cancer Center Auditorium, UC Davis School of Medicine and Medical Center. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## March 4

**20th Annual Diabetes Symposium.** Sheraton Sunrise Hotel, Sacramento, Calif. Sponsored by the Office of CME, UC Davis School of Medicine and Medical Center. Category I credit: 6 hours (approx.) For more information, call (916) 734-5390.

## March 5-10

**21st Annual Critical Care Medicine Course.** Marriott Hotel, Oklahoma City. For more information, call Ms. Dora Lee Smith, (405) 271-5904.

## March 6-11

**Update in Clinical Medicine.** The Radisson, Vail, Colorado. Category I credit: 19 hours. For more information call Steven Smith, George Washington University Medical Center, (202) 994-4285.

## March 12-13

**Laparoscopy in Urologic Surgery: Radical Perineal Prostatectomy.** Tulane University Medical School. Category I credit: 12.5 hours. Sponsored by the Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## March 17-19

**Human Genetics in Clinical Practice.** Holiday Inn Superdome, New Orleans. Sponsored by the Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.



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**Doctors Building**  
**500 South University, Suite 707**  
**Little Rock, Arkansas 72205**  
**(501) 671-5505**

# Keeping Up

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## **Dual Abuse: Substance and Child Abuse**

January 18, 6:30 p.m., Education Bldg., Baxter County Regional Hospital, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Kelly James Kelleher, M.D. and Mark Chaffin, Ph.D. Category I credit: 2.0 hours.

## **4th Annual Physician Update**

February 12, 7:15 a.m. - 3:30 p.m., Center for Health Education, St. Vincent Infirmary Medical Center, Little Rock. Sponsored by St. Vincent Infirmary Medical Center and presented by the Office of Continuing Medical Education. Fee: \$25. Category I credit: 5.5 hours.

## **Vascular Intervention**

February 15, 6:30 p.m., Education Bldg., Baxter County Regional Hospital, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Matthew Kyle McAlister, M.D. Category I credit: 2.0 hours.

## **Advances in Treatment of Diabetes**

March 15, 6:30 p.m., Education Bldg., Baxter County Regional Hospital, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Robert A. Sweet, M.D. Category I credit: 2.0 hours.

## **Recurring Education Programs**

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

### **FAYETTEVILLE-VA MEDICAL CENTER**

Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

Continuing Medical Education Luncheon, Jan. 14 & 28, Feb. 11 & 25, 12:30 p.m., AMI Ozark - Quapaw Room

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.  
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Cancer Conferences, Thursdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., Conference Room 1  
Breast Conference, 3rd Thursday, 7:00 a.m., Conference Room 1  
GI Conference, 4th Friday, 11:30 a.m., Conference Room 1  
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library  
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.



**NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Chest & Problems Case Conference*, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Medicine Conference*, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Surgery Conference*, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*X-ray Case Conference*, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

**LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D

*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

#### **EL DORADO-AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

#### **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

#### **FORT SMITH-AHEC**

*Advances in Plastic Surgery*, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Tuesdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center

#### **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Harris Hospital Tumor Conference*, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO



*Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro*  
*Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.*  
*Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.*  
*Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom*  
*Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.*  
*Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria*  
*White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom*

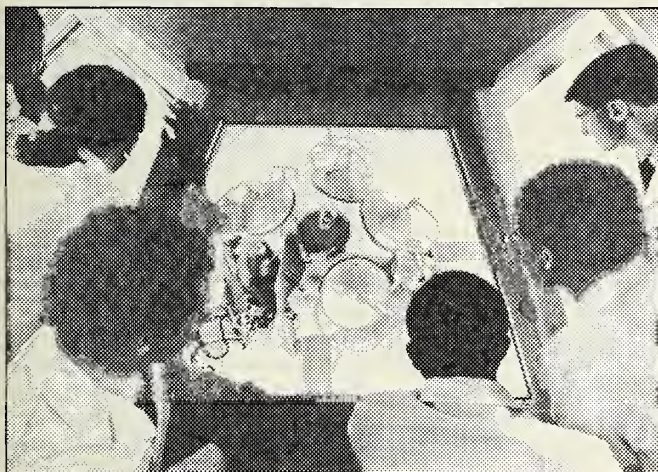
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*Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center*  
*Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center*  
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*Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center*  
*Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center*  
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*Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center*  
*Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center*  
*Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.*  
*Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center*  
*Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center*

#### **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center*  
*Chest Conference, every other 3rd Wednesday, 12:30 p.m., St. Michael Hospital*  
*Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center*  
*Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center*  
*Residency Noon Conference, Tuesdays, Wednesdays and Thursdays, 12:30 p.m., AHEC-Southwest Family Practice Clinic*  
*Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center*  
*Tumor Board, Fridays, except 5th Friday, 12:00 noon, Wadley Regional Medical Center & St. Michael Hospital*  
*Tumor Conference, every 5th Friday, 12:00 noon alternates between Wadley Regional Medical Center & St. Michael Hospital*  
*AHEC Tumor Board, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital*

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One of America's shining stars of the speaking industry, Michael F. Staley will be the keynote speaker at the First House of Delegates on Thursday, April 7, 1994 at 5:00 p.m. in the Ballroom of the Excelsior Hotel.

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# Remember Who You Are

Lee Abel, M.D.\*

*"Remember who you are." He had heard those words countless times and from no less an oracle than his grandmother. She used the phrase frequently, addressing him, his sisters, and even on momentous occasions his father. It was more than a shibboleth; it had become an incantation.*

*The words were her wisdom, the essence distilled from eighty years of joy, sorrow, confusion, serenity, and finally overweening assurance. Her wisdom was all she had to give. She gave it freely, but she never wasted it. The words were always appropriate, never adulterated with further specifics or moralizing. "Remember who you are."*

*She had thus admonished him this morning as she removed her snuff brush and wiped her mouth to accept his good-bye kiss. There was power in the phrase and there was power in the grandmother. She would protect her loved ones as best she could. For a Southerner of family, the words were enough; they covered everything.<sup>1</sup>*

So begins the third novel of Ferrol Sams' trilogy which I have just begun reading. Ferrol Sams is a family practitioner in Fayetteville, Georgia. He practices there in a group of family physicians who happen to include his wife and sons. His first novel of the trilogy, "Run with the Horsemen," describes the hilarious and sometimes tragic events of growing up in the rural South, as seen through the eyes of Dr. Sams' alter ego, Porter Osborne, Jr. The second novel, "Whisper of the River," continues the coming of age saga as Porter goes on to college. The third novel, "When All the World Was Young," describes Porter's adventures at Emory University School of Medicine during World War II and his subsequent service in the war.

Doctor Sams' often ribald sense of humor and keen powers of observation make him a very effective storyteller. His writing shows a deep understanding of human nature, and one imagines that Dr. Sams must be an excellent physician. Perhaps Porter Osborne's grandmother had good advice for practicing physicians in this time of great uncertainty. Perhaps we would do well to "remember who we are." To remember why we went into medicine, and to remember the good we have done, and the good we do every day with our patients.

While the criticism of the medical profession is often very public, our successes are often very private matters. It seems there is no end to the people who would tell us what we are doing wrong, and how we should do better. Often others do have helpful insights, but it will always remain easier to give advice and criticize than to actually do. So let us "remember who we are." Let us remember that though we pursue healing with a variety of different skills and styles, we share the challenges of this inexact science of medicine.

## Reference

1. Sams F. When All The World Was Young. New York: Penguin Book, 1991.

\* Dr. Abel specializes in internal medicine and is affiliated with the Little Rock Diagnostic Clinic.

# The Arkansas Medical Society Seeks Nominations for the 1994 Shuffield Award

The Arkansas Medical Society is seeking nominations for the 1994 Shuffield Award which will be presented at the annual meeting in Little Rock, April 7-9, 1994.

The Shuffield Award is given each year to recognize lay persons in Arkansas who have done outstanding community work in the health care field. The individual might be a newspaper reporter, television personality, government official, teacher or individual promoting a community or other health related program.

The person cannot be a physician or member of a physician's immediate family.

The nominations may come from the county medical societies or any medical society or alliance member. The deadline for receipt of nominations is Friday, February 18, 1994. Past nominees may be renominated.

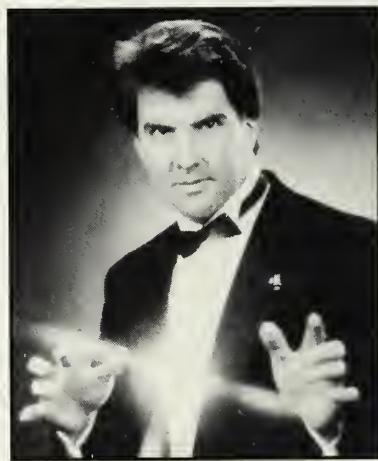
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Please attach a short narrative and a curriculum vitae. (Describe nominee's accomplishments and contributions in the area of health care. Please let us know why this person is worthy of this award.)

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# The Silicone Gel Breast Implant Controversy: Current Status and Clinical Implications

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## ABSTRACT

The silicone breast implant controversy has amassed a great deal of media coverage in the past year. Unfortunately, separating fact from fiction has been extremely frustrating and difficult, not only for physicians but for women who have either had or are considering cosmetic or reconstructive surgery of the breast.

At a recent meeting attended by most of the board eligible and certified Plastic and Reconstructive Surgeons\* in the State of Arkansas, it was felt that a consensus statement was needed to clarify the issues and inform other Arkansas physicians of the most up to date information. The result is a fairly comprehensive review which will require your indulgence.

Breast implants are placed not only by Plastic and Reconstructive Surgeons, but by Otolaryngologists, "Facial Plastic Surgeons", Obstetricians/Gynecologists, General Surgeons, Dermatologists and Family Practitioners. We believe it is the ethical and legal responsibility of the physicians who elect to perform these procedures to provide adequate care and follow-up for these patients when either real or perceived problems arise. Accurate information, reassurance and occasionally re-operations are required for many of these patients.

## INTRODUCTION

More than two million American women have undergone breast surgery with placement of silicone prosthesis since the early 1960s and an additional 150,000 women undergo this procedure per year. Approximately 80% are for cosmetic breast augmentation and 20% are for breast reconstruction from cancer and developmental deformities.

One April 16, 1992, Dr. David Kessler, Commissioner of the Food and Drug Administration, announced the distribution and use of silicone gel-filled breast implants would be available only under clinically controlled trials.<sup>1</sup> Patients who require implants for breast

reconstruction will be assured access to these studies to establish the long-term safety and efficacy of these medical devices.

The decision regarding silicone gel breast implants came out of a routine process at the FDA, which is part of their systematic product evaluation program.<sup>2,3</sup> In 1992, the FDA conducted similar reviews of more than 100 other medical devices. The events regarding the breast implant evaluation have been far from routine.

Reviewing steps the FDA took from Product Evaluation to a moratorium to the current restrictions will clarify the confusion generated by extensive media coverage and debate surrounding this complex and emotional subject.

The purpose of this article is to review rationales for the controversy, clarify the confusion generated by the intense debate in this complex subject, present the available scientific data on breast implants and delineate current status and clinical implication of silicone-gel breast implant for our patients.

In 1976, the U.S. Congress enacted the Medical Device Amendment, which gave the FDA the authority to regulate all medical devices, including breast implants.<sup>2,3</sup> Since the implants were already in wide spread use prior to the law's enactment, these devices were "grandfathered" in, meaning that on the basis of past performance, they were accepted as safe and remained on the market awaiting further study and review.

The manufacturers were not required to provide further scientific evidence regarding the safety of these devices. In June 1988, after public hearings by the FDA Breast Implant Advisory Panel as required by the 1976 law, the FDA classified silicone gel breast prosthesis as Class III devices, which require each manufacturer to provide scientific proof of safety and efficacy, not in generic terms but on each type of device. The deadline for the submission of the manufacturers PMA's (pre-market approval) statement to the FDA was delayed



until 1991.<sup>3,4</sup> In April 1991, a call for the PMA statements from all manufacturers of breast implants was made. Seven manufacturers submitted PMA's. According to the FDA, three contain virtually no clinical information and subsequently failed to meet the requirements that they submit adequate safety and effectiveness data. The remaining four manufacturers did include some clinical information, but provided insufficient data to assure safety and effectiveness.<sup>5,6</sup> Despite these deficiencies, the FDA believed the four applications contained enough clinical data to merit an evaluation by their review panel. The purpose of the panel was to advise the FDA about the safety and effectiveness of these medical devices based on the data from manufacturers.<sup>5,6</sup>

The FDA advisory panel held a hearing in November 1991, at which time the FDA panel recommended that the implants stay on the market while further study and evaluation was undertaken by the FDA.<sup>1</sup> This was followed on January 6, 1992, by Dr. Kessler requesting a voluntary moratorium on the use of silicone-gel implants based upon new data which had not been reviewed at the initial FDA advisory panel meeting, specifically relating to a possible link to autoimmune diseases. Manufacturers complied with the voluntary moratorium.<sup>8,9</sup>

The second FDA advisory panel meeting in February 1992 made nine recommendations.<sup>10,11</sup>

1. Future use of implants should be restricted to women participating in scientific protocols to assess implant safety and efficacy.
2. Women who need breast reconstruction should be allowed unrestricted access to the implants through controlled protocols.
3. Cosmetic augmentation patients in these protocols should be limited to the number needed to answer safety questions about implants.
4. If an implant ruptures, it should be removed. Although "silent" rupture (undetected), can occur, women with implants should not be routinely x-rayed to check if they are not having problems with their implants.
5. Women with implants in the age group where mammography is recommended for breast cancer detection should have these examinations regularly. (Special mammography techniques are necessary to effectively detect breast cancer).
6. Women with breast implants should have regular medical check-ups, even if not experiencing symptoms related to the implants.
7. A prospective registry of patients should be established as part of the scientific protocols and a ret-

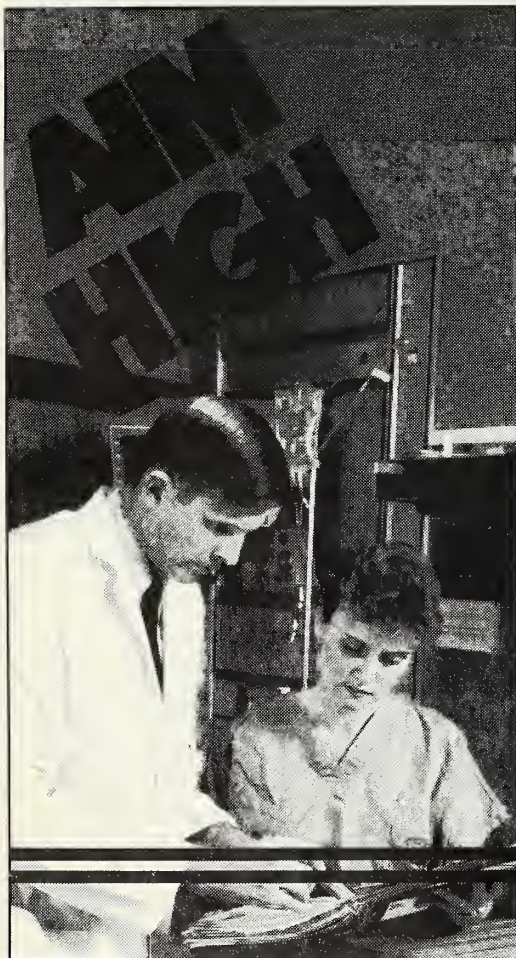
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respective registry be created to enroll women who already have implants.

8. Manufacturers must provide adequate preclinical data on the implants, such as the chemical and physical characteristics of the implant materials and the implants' resistance to stress and rupture.
9. Epidemiological studies should be done to answer questions about possible long-term risks such as whether implants can cause immune-related and connective tissue disorders or increase the risk of cancer.

## CURRENT STATUS

The ruling on April 16, 1992 by Dr. Kessler cited that silicone gel-filled breast implants will be available only through clinically controlled studies and the patients who need implants for breast reconstruction will be assured access to these studies. He stated these new studies will obtain information on the safety and efficacy of these implants.<sup>12,13</sup>

The central aim of the FDA decision was to significantly limit the use of silicone gel-filled breast implants while vigorously pursuing necessary research about their safety. Furthermore, important and necessary research will be carried out on the safety of breast implants when used for both augmentation and reconstruction procedures. All facilities participating in breast implant studies will have the protocol and informed consent document reviewed by the Institutional Review Board (IRB) that oversees medical research projects. The implementation of the breast implant policy will occur in three stages:

### Stage 1: Urgent Need<sup>1,12,14,15,16</sup>

Since FDA's April 16, 1992 decision, women with an urgent need for reconstruction with the implants have been allowed access to them.

This includes:

- women with tissue expanders for breast reconstruction following mastectomy who need to complete their reconstruction with gel-filled implants.
- women with silicone gel-filled implants who need replacement for medical reasons; and
- women having mastectomies before the adjunct study is in place and for whom reconstruction at the time of mastectomy is medically and surgically more appropriate. Physicians must document that saline-filled implants are not a satisfactory alternative.

### Stage 2: Adjunct Study:

#### Reconstruction with Wide Availability<sup>1,14,16</sup>

The Adjunct Study replaced the temporary Urgency Need Provision in late 1992. It provides for wide-access availability of silicone gel-filled implants by sur-

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geons participating in the FDA-approved scientific protocol. The Urgent Need Provision will be phased out as the Adjunct Study is established.

### Patient Selection/Criteria

Female patients at least 18 years of age, not suitable for saline-filled implants, having one or more of the following conditions:

- Post-unilateral or bilateral mastectomy (immediate or delayed) from cancer or other disease process;
- Requires reconstruction due to cancer treatments other than mastectomy;
- Revision due to complications or other undesirable results of a previous surgery for the above reasons;
- Congenital deformities such as pectus excavatum, pectus carinatum, and severe asymmetry defined as congenital or developmental. (e.g., Poland's Syndrome);
- Mammary associated with hypoplasia;
- Severe ptosis requiring a combination of reconstructive procedures (e.g., augmentation/mastopexy);
- Revision or implant replacement for severe deformity caused by medical or surgical complications, regardless of original indication for implantation or type of device originally implanted;
- Replacement or revision for patients whose prior

surgery was not a result of treatment for cancer and for whom saline implants are unsuitable (e.g., skin too thin, insufficient tissue, etc.) as deemed by the surgeon;

- Patients who require augmentation mammoplasty in the unaffected breast as a result of the surgery due to one of the above indications in the affected breast (e.g., unilateral mastectomy with augmentation to the opposite breast to provide symmetry);
- Special circumstances for implantation will be considered on a case-by-case basis per written FDA authorization.

The Stage 2 protocol excludes women who have any of the following symptoms or characteristics:

- Abscess or infection anywhere in the body
- Pregnant or nursing
- Diagnosed with lupus or scleroderma
- Uncontrolled Diabetes or other disease which impacts healing
- Inappropriate psychological characteristics and/or insufficient motivation to complete study
- Incompatible tissue characteristics, such as;
  - tissue damage from radiation
  - inadequate tissue
  - compromised vascularity
  - ulceration
- Unwarranted surgical risk

### Requirements for Participating Patients

Patients enrolled in those protocols must agree to the following study requirements:

- Understand and sign a detailed informed consent form.
- Receive follow-up examinations after surgery and periodically for five years thereafter.
- Consent in advance the return of explanted devices to manufacturer for examination.
- The FDA believes there is scientific benefit to evaluating explanted breast implants and will oversee the manufacturer's evaluation of these devices.
- Results of the evaluation would be available to both patient and physician.

### Requirements for Clinical Investigators

Plastic Surgeons who implant silicone gel-filled breast implants under the Stage 2 protocol will be required to:

- Use a special consent form approved for the Stage 2 protocol, available from the manufacturer of the device that will be implanted.
- Certify that the patient meets all inclusion criteria, and that saline implants are not a medically satis-

factory alternative for this particular patient.

- Keep comprehensive records on the patient's health prior to the operation, the details of the surgery and follow up checkups including any complications.
- Give each patient a record of the implant(s) she received, including the brand and model, identifying characteristics and implant placement.
- Must have protocol and informed consent approved by the Institutional Review Board (IRB) in charge of medical research in the particular facility or hospital. Clinical investigators affiliated with an institution can work with their local (hospital) IRB's which can waive their review in deference in the national IRB established by the manufacturer.

Women who are eligible and want to enroll in the Stage 2 protocol should contact their physician, and/or their plastic surgeon.

### Stage 3: Core Studies:

#### **Trials of Limited Enrollment<sup>1,14,16</sup>**

The FDA will require carefully controlled research studies for each model of silicone implant manufacturers wish to continue marketing. The studies will be limited to a select number of patients required to answer specific safety questions. This category includes both reconstructive and cosmetic patients.

These studies will focus on specific safety questions, such as the incidence of implant rupture and scar tissue (capsular contracture). Women in these studies will be followed prospectively to check these problems.

### The Informed Consent

The FDA requires that Informed Consent Documents be signed by all women prior to breast implant surgery. She must indicate that she understands the procedure and risks described by her physician.

Each patient must be told that if manufacturers fail to prove these implants are safe and effective in long-term studies, they will be taken off the market.

Surgical risks, known risks of breast implants and unanswered questions about long-term safety issues are presented. The consent form includes mention and discussion of the following:

- Surgical risks - infection, bleeding, problems with anesthesia, pain, scarring and decreased nipple sensation from breast nerve damage.
- Some of the known risks of breast implants: capsular contracture, calcium deposits in tissue around the implant, granulomas, gel "bleed", implant rupture, interference with mammography, changes in nipple and breast sensation, interference with breast feeding.
- Unanswered questions pertaining to cancer, con-



nective tissue disorders, cancer detection, implant rupture and birth defects; life span of the implants.

There is no available research to demonstrate that silicone gel-filled breast implants can cause birth defects. However, the FDA has required manufacturers to conduct studies on this issue and submit them for review.

Physicians must also discuss the need for ongoing research into the long-term psychological benefits of breast implants, as well as the variety of problems that could require removal of the implant in the future.

An analysis of the major health concerns raised due to the recent debates about silicone gel breast implants include:

1. Cancer development
2. Cancer detection
3. Implant rupture/gel migration
4. Autoimmune Disease

### Cancer Development

The potential carcinogenicity of cancer development in any foreign implant has been a concern since Oppenheimer and colleagues<sup>17</sup> in 1948, demonstrated that any smooth surfaced material implanted in the peritoneum of rats will induce sarcomatous changes. The "Oppenheimer effect" of solid-state tumorigenesis refers to this unique, morphologically stimulated fibrosarcoma specific to rodents.

Numerous authors<sup>18-22</sup> have investigated the possible carcinogenicity of breast implant materials. These studies confirm the occurrence of allogeneically induced soft-tissue tumors in rodents, as well as a variable effect of the implanted substance on cellular immunity.

There are only two clinical studies addressing the potential breast cancer risk associated with implants. Deapen et al,<sup>23</sup> followed the course of 3,111 women after augmentation mammoplasty for a mean 6.2 years per person. The expected number of breast cancer cases in this population was calculated from census figures and tumor registry data, adjusted for age and socioeconomic status. Overall, 15.7 cases of breast cancer were expected and 9 were observed a nonsignificant difference. The cancers were generally diagnosed at an early age.

Recently, Berkel, Budsell and Jenkins<sup>24</sup> performed a population-based nonconcurrent cohort-linkage study on 11,676 patients. The expected number of breast-cancer cases in the implant cohort was estimated by applying age-specific and calendar year-specific incidence rates of breast cancer to the implant cohort. Forty-one patients with implants were found to have breast cancer. The expected number was 86.2. The standardized incidence ratio was 47.6%, significantly lower than expected ( $P < 0.01$ ). The average length of follow-up in the implant cohort was 10.2 years, and the average

length of time from breast augmentation to the diagnosis of breast cancer was 7.5 years. The authors concluded that women who undergo breast augmentation with silicone breast implants have a lower risk of breast cancer than the general population. This study suggested that these women are drawn from a population already low at risk and that the implants did not increase the risk.

Although there is no evidence that silicone used in breast implants causes cancer in humans, the possibility has not been ruled out. The National Cancer Institute (NCI) is sponsoring a scientific study to determine whether women with silicone gel-filled implants have higher or lower rates of some cancers (such as cervical and lung cancer) than women without implants.<sup>14</sup>

### Cancer Detection

Silverstein et al<sup>25</sup> in 1988 found invasive breast cancer in 13 of 20 women who had breast augmentation with silicone gel-filled prostheses. This is significantly higher than expected from the general, non-augmented population. The authors implied that the prostheses delayed the diagnosis and management of breast cancer. There are several problems with this study:

1. All of the augmented patients in this study presented with a palpable mass. The patients were not routinely screened with mammography and those that had mammography did not have appropriate modified studies to optimize tissue visualization, i.e., modified compression techniques now accepted as the standard for imaging the augmented breast. No conclusion can be drawn about the likelihood of delayed mammographic detection of breast tumors in this patient population.
2. No comment is made about the extent or frequency of self examination or risk factors such as family history in either group.
3. The study cannot be taken as authoritative on the effects of implants on radiographic screening since none of the patients involved in this study had "occult" lesions, but rather, all presented with palpable lesions, which by definition, is associated with more advanced disease.

In contrast, Clark<sup>26</sup> et al recently examined 33 patients from a cohort-controlled population of 1,768 patients treated for breast carcinoma. Twenty-four percent of the augmented patients and 41% of the nonaugmented patients had mammographically detected cancers ( $p = ns$ ). The incidence of duct cell carcinoma in situ in the two groups were comparable; however, palpable tumors in the augmented group were significantly smaller than those in the nonaugmented group. Overall, a significant difference in nodal involvement was detected, with 19% of the augmented group

and 40% of the nonaugmented group demonstrated positive nodes. In the palpable tumors, nodal involvement also was significantly different, with 21.8% of the augmented patients and 57.6% of the nonaugmented patients demonstrating nodal disease. In the mammographically detected tumors, there was no significant difference between the augmented (12.5%) and the nonaugmented (14.8%) patients. Mammography was successful in detecting occult lesions and palpation detected smaller tumors. There was no evidence to suggest that these patients had more advanced disease at presentation in this cohort study.

In another mammographic visualization study, Handel, Silverstein et al<sup>27</sup> studied 68 women after augmentation and found a 30% decrease in the area of breast tissue visualized by standard compression mammography or with the use of displacement mammography (Eklund technique<sup>28</sup> in which the implant is pushed backward while glandular tissue is brought forward), a 25% decrease. However, the authors acknowledged they don't know whether they are actually seeing less tissue or whether the tissue has simply been compacted into a smaller volume as a result of compression by the breast implant.

Furthermore, the study suggest that displacement mammography results in only about 5% more breast tissue being visualized compared to compression mammography. This is less of an increase than was generally expected; however, the research fails to determine whether the combination of displacement and compression techniques, which is generally recommended for women with implants, results in a higher percentage of total breast tissue visualized.

Interestingly, the study indicates that women with very small breasts who undergo augmentation may actually increase the amount of breast tissue visualized by mammography. Other studies have also shown that breast implants may make it easier to detect early stage tumors by palpation, since the implant may push the tumors closer to the surface where they can be felt. However, the significance of these findings is yet to be determined.

The study shows 6.4% of 139 postaugmentation mammographic studies were of patients with moderate to severe capsular contracture (excessive breast firmness caused by tightening of scar tissue around the implant). In these cases, visualization of breast tissue was reduced by about 50%. However, as the authors noted, contracture can often be corrected by using a different style implant or modifying the implant placement.

Eklund and co-authors<sup>28</sup> modified the standard mammographic technique by adding breast compression anteriorly, flattening the implant against the chest wall, and demonstrated marked improvement in glandular visualization.

Gumucio et al<sup>29</sup> stated that the degree of radiodensity of an implant is proportional to the cube of its atomic number. They tested silicone shells filled with silicone gel, silicone gel and saline, saline alone, polyurethane-covered silicone gel, gelatin, peanut oil and sunflower oil. All materials obscured radiographic visualization of phantom artifacts except for the oils, whose atomic numbers approximate that of carbon.

### Implant Rupture/Gel Migration

In 1981, a survey of the complications in 5,579 open capsulotomies revealed 16% of breasts had ruptured implants, (57% had previous closed compression for firm capsules.<sup>30</sup>) Ruptured implants are "silent" and only discovered at the time of routine mammograms or at surgery for implant exchange. It is important to point out that this study only looked at patients having breast problems. No clinical sequelae of implant rupture have been definitely identified to date. However, the incidence of overall silicone gel ruptures is thought to be considerably less (4-6%) in the overall silicone gel implant patient population.

Physical findings consistent with implant rupture include nodules, decreased breast size, asymmetry, tenderness and compressibility. Mammograms were largely diagnostic of implant rupture when the silicone gel had migrated away from the pocket but not when the silicone is contained within the fibrous capsule.

Mammography itself although quite infrequently may exert sufficient pressure on the breast to rupture an implant. Elkund<sup>31</sup> reported collapse and complete deflation of a saline-filled implant after routine two-view mammography. The patient had suffered no breast trauma other than having her breast squeezed under the compression paddle for the mammographic study. The modified displacement technique of mammography is less traumatic and less likely to cause implant rupture than the conventional technique.

The value of ultrasonography in the diagnosis of breast implant rupture has recently been reported.<sup>32,33,34</sup> Ultrasonography can accurately distinguish between silicone gel, muscle, hematoma and fluid collections. MRI has also been used to increase the accuracy of detecting implant ruptures preoperatively. Further studies are needed to assess the potential value and accuracy of both ultrasound and MRI in detecting silicone gel implant rupture.

Silicone gel migration out of a ruptured implant and into the surrounding tissues is more common after closed capsulotomy (2.5%) than open capsulotomy (2.3%).<sup>35</sup> Capsular contracture, silicone gel granulomas<sup>36</sup> and chronic disseminated granulomatous inflammation have been associated with implant rupture and gel migration, but the frequency of these complications is unclear.



Autoimmune Disorders

There are a group of disorders in which the body reacts to its own tissues as though they were foreign bodies. These connective tissue disorders can cause long-term, serious health problems. Symptoms include pain and swelling of joints, tightness, redness or swelling of the skin; swollen glands or lymph nodes; unusual and unexplained fatigue; swelling of the hands and feet; and hair loss. Some cases of these disorders have been reported in women with breast implants.

The term "human adjuvant disease" described by Miyoshi et al<sup>37</sup> in 1969 attributed a connective-tissue like illness in two patients whose breasts had been injected with paraffin for augmentation. The "adjuvant" comes from the similarities they noted between their patients' clinical symptoms and the polyarthritis that developed in rats injected with Freund's adjuvant. Several investigators<sup>38-43</sup> have reported the development of connective-tissue illness-progressive systemic sclerosis, scleroderma, rheumatoid arthritis, lupus erythematosus, etc. in patients with breast prostheses.

Sergott et al<sup>44</sup> and Weisman et al<sup>45</sup> reviewed the literature of autoimmune disease after breast augmentation and found no compelling evidence of an etiologic role for silicone implants. The coexistence of implants and an autoimmune disorder may be coincidental, since autoimmune disease tends to occur in young, thin women, and these are the same individuals who request breast augmentation.

The American College of Rheumatology released a statement on this issue after the second FDA advisory panel.<sup>46</sup> They agreed that there was no convincing evidence that silicone gel breast implants cause any generalized autoimmune disease but recommended further study.

For women with implants who are doing well, the FDA advisory panel recommends regular breast examination and mammography, noting that special views are usually required to obtain satisfactory mammograms. Women with chronic rheumatic symptoms should, of course, be carefully evaluated, although the likelihood that any symptoms are related to silicone implants is extremely low.

Management of patients with symptoms should be on a case by case basis by the appropriate physicians, usually a rheumatologist and a plastic surgeon.

Some women have a reduction in symptoms after their implants were removed, however, this data is early and inconclusive. More research needs to be done to determine if women with implants have higher rates of autoimmune diseases than women without implants. Due to concern about a possible link between breast implants and connective tissue disorders, FDA has required manufacturers to sponsor large-scale scientific studies. The specific autoimmune study results are expected no sooner than 1997.

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## Role of Breast Implant Removal (Explantation)

The conflicting media coverage of the breast implant issue has created fear and concern in thousands of women.

It is important to explain that removal may not be necessary.<sup>47,48</sup> The FDA advises that women who are not experiencing any problems with their breast implants need not have their implants removed. The normal risk associated with all surgical procedures is likely to be greater than any real or speculative risk of retaining implants.<sup>12,13,47</sup>

Optimally, women with concerns about their breast implants should consult the surgeon who originally implanted them. If the patient is unable to contact her original surgeon, she should consult a board eligible/certified plastic surgeon in her community.

The American Society of Plastic and Reconstructive Surgeons (the largest group of board certified plastic surgeons in the United States) has established a special program known as the Breast Implant Patient Relations Network (BIPRN). Its members will personally call the patient who needs consultation within 48 hours. If telephone consultation is deemed insufficient, he or she will see the patient in the surgeon's office for an initial consultation at no charge. Interested women can call 1-800-635-0635.

In addition, the plastic surgeon will advise the patient of sources of reimbursement or financial support, including breast implant manufacturers.<sup>49</sup>

## CONCLUSION

What we have learned much from this controversy, however, is that it is essential to separate fact from fiction engendered by the media coverage. The pertinent points we have learned thus far from this controversy are:

- Breast implants like all other implant material used in humans can not be expected to last a lifetime. No one knows how long they will last.
- All breast implants leak a small amount of silicone gel through the hard silicone envelope.
- It is not known how often rupture and gel migration occurs, but it is more likely in older devices, those dating before 1981.
- There is insufficient data to determine a link between breast implants and rheumatic disease, such as scleroderma and lupus.
- All women with implants should have regular check ups and follow established cancer detection procedures.
- There is no known association between breast implants and cancer.
- There is no need for those women who currently have breast implants and are not experiencing any problems to have the implants removed according to the FDA. (The surgical risks of removal are

greater than leaving the implant in place.)

- The saline-filled implant remains a good alternative in patients requesting breast reconstruction and cosmetic breast augmentation.
- The patient and practitioner seeing the patient can readily obtain information on this subject from a plastic surgeon in their area and are encouraged to do so.
- Further research is needed and currently underway to delineate and answer these questions for the welfare of our patients.

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# Concepts of Externally Powered Upper Limb Prostheses

Frank Snell, C.P.O.\*

With the appearance and demise of the 1970s television series "The Six Million Dollar Man," many in the medical field wonder where the reality of the externally powered prosthetic device is, and just where in the near future it is going. The purpose of this article will be to provide a brief history of the subject, concentrate on the current applications being utilized across our country, and to project where the present research might take us in the coming years.

While some early work was done by several researchers in the years between the two World Wars, these were, by current standards, crude and simplistic. American and European designs featured prosthetic hands powered by artificial muscles activated by CO<sub>2</sub> gas contained cylinders. None of these systems were strongly marketed and were only a stepping stone in the path to modern technology.

World War II, and the large number of traumatic amputation cases, brought a new interest and dedication to the quest for successful research in the control and fitting of powered upper limb prostheses. In the United States, the government established the Committee on Prosthetic Research and Development (CPRD) of the National Research Council, which for twenty five years was the guide for all field work done in this area. Private research from companies such as IBM, as well as institutional efforts from the Veterans Administration, were successful in developing technology leading to our present level of prosthetic applications.

In the decade between 1967 and 1977, the current technology was finally removed from the laboratory and made commercially available to the general amputee population. The Viennatone Hand was the first externally powered prosthetic hand sold widely in the

United States and Europe. This hand was the result of efforts between Otto Bock Orthopedic Industries, and Viennatone, an Austrian hearing aid company. Though the design was a giant leap forward, the system required an external pouch to be worn outside the prosthesis to house the electronics and the battery pack. Broken wires and electrical interference were common with this system.

Paralleling this experience, in 1968, the first self contained and self suspended below elbow prosthesis was developed by researchers at Northwestern University in Chicago, which combined the Viennatone Hand and a myoelectric controller produced at Northwestern. This system would later be known as the VAPC-NU Hand, and was manufactured by Fidelity Electronics, Ltd. for several years and distributed by the United States Manufacturing Company. The Viennatone Hand was gradually replaced by a similar system produced by the Otto Bock Orthopedic Company which has invested a great deal of energy into the current state of external power technology. Truly, in the 1970s, prosthetic research was taken from the drawing board, manufactured by commercial facilities, and made available to the general amputee population.

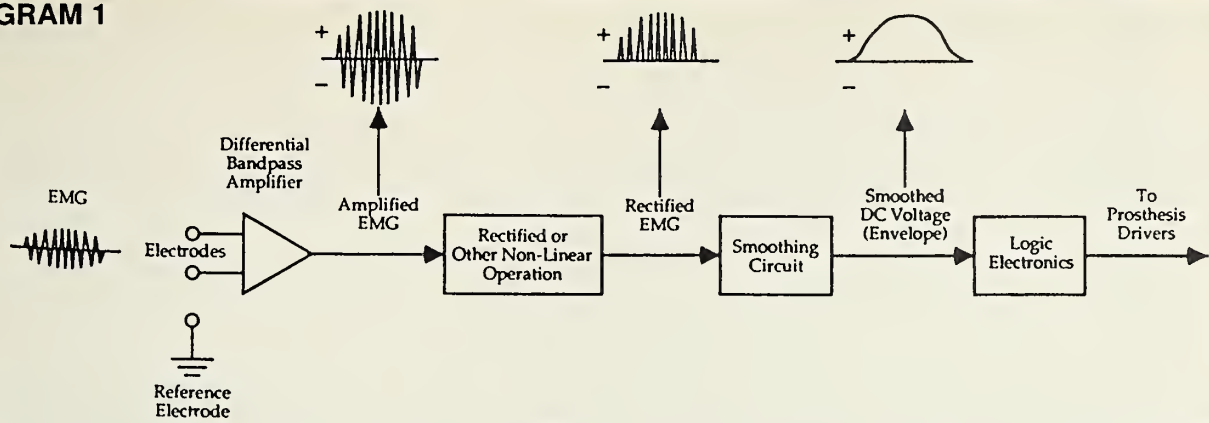
Through the 1980s and into the 1990s, further refinement and development continued. Private companies such as Liberty Mutual (Boston Elbow) and Motion Control (Utah Arm) earned their place in the market, and Otto Bock Orthopedic Industries continued to develop as the premier supplier of external powered prosthetic hands in the world (see photo 1).

In the current concept of external powered prosthetics two prominent control systems have developed which can be utilized to direct the function of the prosthesis. These are myoelectric and switch control. The most common of these concepts is the myoelectric control (see diagram 1) in which surface electrodes are fabricated into the prosthetic socket in a stationary fashion and come into direct contact with the skin under

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**DIAGRAM 1**



which the muscle tissue lies. When the muscle is activated by a normal contraction, the electromyographical signal (which is measured in microvolts) is received by the electrode, multiplied by an amplifier, and then sent to the processing unit which acts as an electronic switch, signaling the motor to turn clockwise or counter-clockwise. The tiny motor is powered by a self-contained nickel-cadmium rechargeable battery. In a conventional system, two electrodes are contained in the socket and placed over antagonistic muscles to provide opening and closing of the hand. In the most advanced cases where hand and wrist function will be prosthetically replaced, one electrode can be used to provide two independent functions based on the identification of the strength of the muscle contraction. This is known as a double channel electrode control.

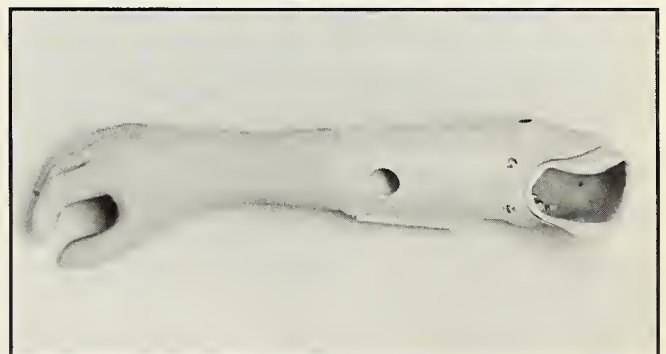
In extremely short amputations, when only one muscle site remains intact, the double channel electrode can be used to provide both opening and closing of the hand. Therapy is sometimes necessary to educate and reinforce the control of these muscles, so the resulting hand function is clear and free from any undesired motion.

The other choice of control is switch control. In this design the activation of the device is not based upon muscular contractions, but on the activation of one or more switches designed into the prosthesis. These switches can be of a rocker or button type, which can be triggered by phocomelic digits, or a pull switch, which is built into the harness system and activated by body motions. The switch control, though very effective, is a more mechanical design and not as natural as the myoelectric control (see photo 2).

Though the hand has been the center of most of the attention regarding the research and development into external powered prosthetic systems, some work has been done concerning elbow joints and even hook type terminal devices. Three elbow units, the Boston Elbow, the Utah Arm and the Hosmer Elbow are all prominent examples of such production of elbow systems. Otto Bock Industries has developed the "Greifer" which is recognized as a working man terminal device for their

myoelectric system. After many years of research and development, Hosmer has marketed the "Synergetic Prehensor," which is a true myoelectric hook type device.

In this article I have tried to present a brief overview of the milestones regarding the development of external powered upper limb prosthetic systems. Where will the future take us? In my opinion we will see further improvements, both in electronics, batteries, prosthetic control and design. We will see the advent of computer technology in the mainstream of advanced prosthetic thinking, and we will see the increased sharing of information between systems as better educated prosthetists continue to apply technology to improve in the lives of the patients we serve. ■



**Top:** Photo 1; **Bottom:** Photo 2.



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# Arkansas Foundation for Medical Care Report: Preventing Stroke in Atrial Fibrillation

William E. Golden, M.D.\*

Mario Cleves, Ph.D.\*\*

Consistent with the mission of the Arkansas Foundation for Medical Care as described in the Health Care Quality Improvement Initiative of the PRO program Fourth Scope of Work, the AFMC has recently conducted a focused review of the prevalence and methods of stroke prevention therapy in patients with atrial fibrillation. This report describes the findings.

Non-rheumatic atrial fibrillation is a common disorder of the elderly. Studies estimate that approximately three percent of patients between the ages of 60 and 69 have this arrhythmia and that up to nine percent over the age of 80 have atrial fibrillation.<sup>1</sup> A review of the Medicare database for the ICD-9 codes for atrial fibrillation documented that over 19,000 patients in Arkansas carried the diagnosis of atrial fibrillation in fiscal year 1992.

**Atrial fibrillation in the elderly increases the risk of stroke by five times when compared to patients in sinus rhythm.<sup>2</sup>** Studies estimate that a population of patients with atrial fibrillation will suffer stroke at the rate of five percent per year. This risk is especially pronounced in patients with coexistent coronary artery disease or congestive heart failure. It should be noted, however, that younger patients with normal hearts and atrial fibrillation, a condition known as lone atrial fibrillation, do not share this increased risk for stroke.

**Several recent studies have clearly demonstrated that Warfarin will reduce the risk of stroke in patients with atrial fibrillation by nearly two-thirds.<sup>3-7</sup>** A prolongation of the prothrombin time to between 1.2 and 1.5 times the control, or to an INR of 1.5 to 3, has repeatedly been effective in reducing stroke to one and

one-half percent a year. Moreover, in this selected population under the guidance of study researchers, the incidence of significant bleeding associated with the use of this anticoagulation therapy was between .3 and .5 percent. These studies have limited the use of Warfarin to patients under the age of 80 and researchers have postulated that perhaps 30% of the elderly population with this arrhythmia would be eligible and compliant with the use of anticoagulation. Aspirin, which would be much simpler to administer and use, has only had mixed success in the clinical trials. Low dose aspirin, 75 mg per day, was not effective in one European study.<sup>3</sup> Three hundred and twenty-five milligrams a day of aspirin showed a 25% reduction in strokes, a much lower efficacy than Warfarin, and the sample size did not completely rule out the possibility that this reduction was a statistical as opposed to a therapeutic effect.<sup>8</sup> **This has lead researchers to conclude that aspirin could be useful but that Warfarin has definite therapeutic impact.**

The use of Warfarin clearly has associated costs and risks. One European study examined the cost benefit of this therapy and concluded that, when one examines nursing home costs and the impact of strokes versus the activities associated with maintaining a patient on Warfarin, the cost benefits of prophylaxis are worthwhile unless the complication rate reaches two percent per patient per year.<sup>9</sup> Clearly a carefully selected patient population and the use of lower intensive doses of Warfarin have a major bearing on the decision to implement such prophylaxis on a widespread scale.

**The Arkansas Foundation for Medical Care conducted a focused review on patients randomly selected for the diagnosis of atrial fibrillation.** The sample was constructed so that we could analyze differences in the use of this modality between large and small hospitals and by region of the state. Three hundred and fourteen charts were reviewed for the use of aspirin, and Warfarin, the diagnosis of atrial fibrilla-

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tion, and the presence of contraindications for such therapy such as alcoholism, dementia, frequent falling. We also examined whether the patient had suffered a previous stroke.

Of the 314 charts, 244 were of patients 85 and under with documented atrial fibrillation. Twenty-two percent of this population was receiving Warfarin and 23% were receiving aspirin. Forty-three percent received either aspirin or Warfarin. Twenty patients had documented reasons for not receiving Warfarin. The use of Warfarin decreased with age. Comparison of Warfarin prophylaxis between hospitals greater than or equal to 100 beds and those hospitals smaller than 100 beds demonstrated differences in stroke prevention activity. **Patients in larger hospitals were more likely to receive Warfarin ( $p=.036$ ) or receive either Warfarin or aspirin ( $p=.017$ ). Patients cared for in Central Arkansas were also more likely to be placed on Coumadin (29.2% vs. 19.2%,  $p=.087$ ).**

Of the 244 patients, 37 or 15.2% had a previous stroke. Interestingly, a high proportion of patients who had suffered a stroke were now receiving Warfarin prophylaxis (40.5%). We further subdivided our sample to examine prophylaxis of stroke in patients under the age of 80 who suffered from atrial fibrillation but had not yet had a stroke. Twenty-one percent of this population were receiving Warfarin and 42% were receiving either Warfarin or aspirin. Again, there was a difference between the prevalence of use of Warfarin between large and small hospitals but this difference did not reach statistical significance most likely because of the smaller sample size. On the other hand, when one examines the use of either aspirin or Warfarin in this group receiving primary prophylaxis for stroke, the difference in activity between large and small hospitals did attain a  $p$  value less than .05.

The Arkansas Foundation for Medical Care does not know what the ideal prevalence of Warfarin for stroke prevention in atrial fibrillation should be. Nor does it have data on the frequency of complications from Warfarin therapy in the state. It does note, however, that there is a greater tendency to use this modality in larger hospitals in the state. It, therefore, believes that all hospitals, particularly small hospitals, might reflect on this data and examine whether the use of Warfarin and aspirin in elderly patients with atrial fibrillation should be and could be extended to a larger percentage of this population.

## SUMMARY

1. Atrial fibrillation is a common disorder in the elderly.
2. Atrial fibrillation increases the risk of stroke five times that of patients in sinus rhythm.
3. Warfarin reduces the risk of stroke by two-thirds in this population. Aspirin might reduce the risk of

stroke but by a lesser amount.

4. In this sample, statewide use of Warfarin for primary prophylaxis in patients under 80 was 21% (95% C.I. 14-28%) and use of either Warfarin or aspirin was 42% (95% C.I. 34-50%).
5. Smaller hospitals and hospitals not in Central Arkansas use Warfarin less frequently than larger institutions for prophylaxis of stroke. Likewise, these hospitals are less likely to give any stroke prophylaxis to patients with this condition.

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The analyses upon which this article is based were performed under contract number 500-93-0505, entitled *Operation and Utilization and Quality Control Peer Review Organization (PRO) for the State of Arkansas*, awarded under Title XI of the Social Security Act by the Health Care Financing Administration, Department of Health and Human Services.





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James R. Coffield  
Vice President-Investments



Todd Smurl  
Financial Advisor

## Socially Responsible Investing

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*"I believe it is my duty to make money and still more money and to use the money I make for the good of my fellow man according to the dictates of my conscience"*

— John D. Rockefeller

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Socially responsible investing was once the domain of religious groups seeking to avoid the so-called sin stocks and anti-war protestors refusing to invest in weapons contractors. Its scope increased dramatically in the 1980s as corporate involvement in South Africa became a major issue; socially responsible investing soon came to include not investing in companies with ties to South Africa. Private investors, corporations and pension funds divested their holdings. Many local governments refused to do business with any individual or corporation which had South African connections. Ethical investing became recognized as a force for affecting change.

Since then, many investors have come to realize that socially responsible investing is a powerful tool to give voice to their beliefs. While the variations of socially responsible investing are too numerous to mention here, they do include such general areas as favoring firms that have proactive environmental and labor relations records and avoiding those that manufacture weapons, tobacco, alcohol or gambling products. For some, nuclear utility manufacturers must be avoided. For others, companies with manufacturing facilities in Northern Ireland that decline to subscribe to a code of

equal employment opportunity are an issue.

Using social criteria to guide your investments develops out of your desire to influence corporate practices on those issues which are important to you. New topics of interest will constantly arise, stimulated by political events, natural catastrophe, domestic problems and your personal beliefs.

### Stereotypes vs. Reality

Mention socially responsible investing to your acquaintances and they are likely to say it's just a passing fad which should be ignored. These comments may stop you from developing a set of social criteria for your investments. It shouldn't. Socially responsible investing pertains to all ideologies and can be utilized by any investor who wishes to direct investments based on his, or her, convictions.

Many people are acting on their convictions. The amount of individual assets ethically invested is virtually impossible to measure. However, in the United States, investments made according to some social criteria grew from \$40 billion in 1984 to approximately \$625 billion in 1992. (This most recent figure included money managers, mutual funds, state pension funds, religious institutions and other institutional investors.) Clearly, socially responsible investing has become a broadly accepted practice.

### Types of Socially Responsible Investing

There are three ways in which socially responsible investing can work for you:

1. **Activist.** You may wish to identify a company with products or practices which you feel are not socially responsible and invest in that company. As a shareholder, you will be able to proactively work from within the company to produce changes in corporate philosophies or practices. For example, you might invest in a company which uses animals for testing products and work from within to change their testing procedures.



2. **Avoidance.** You may wish to identify companies with products or practices which make them unsuitable candidates for your investment. As situations change, you may also wish to screen your current portfolio to determine if any of the companies you hold have begun to engage in practices you feel are not socially responsible. For example, you may wish to avoid investing in a company within the tobacco industry.
3. **Investment Opportunities.** You may wish to identify companies whose products or practices you view as positive and invest in them as a means of supporting their efforts and encouraging other corporations to follow suit. For example, you might invest in a defense company which is undergoing a peacetime conversion to alternative products.

## The Mechanics of Socially Responsible Investing

Once you decide to direct your investments according to a set of social criteria, you have to develop the criteria, research potential investments and implement your plan. You are the only person who can determine the standards you will use to judge a company. Once you have developed your set of social criteria, the investigative process begins.

Research into a corporation's practices can be a difficult and time-consuming task. Companies may be hesitant to release information on sensitive topics; you may have to consult other sources of information. These include:

- Special interest groups
- Court cases
- Newspaper and magazine articles
- Corporate annual reports and other public relations material

If you are a socially responsible investor seeking to take an activist role in a company, you must also decide which practices you will focus on and develop an action plan.

If you call a financial advisor or money manager and request a socially responsible investing program, you may receive nothing more than a mutual fund prospectus (which may have good results, but will not be tailored to your specific concerns). Or, you may be told such a program is not available. Prudential Securities formed its Social Investment Research Service as a result of client requests for information other than financial.

The Social Investment Research Service (SIRS) has developed data bases which are utilized to screen companies for investors. SIRS does not make judgements on past performance, nor does it offer opinions on fu-

ture performance. Its sole function is to screen companies against any issue of corporate responsibility which is requested by clients.

Socially responsible investing should not be confused with charitable giving. It is possible to construct a portfolio which meets your financial goals and objectives as well as your social goals and objectives and has the same potential for growth as a portfolio that isn't structured according to a set of social criteria. Socially conscious investors may also include municipalities, religious organizations and others who invest in projects which will benefit the community (i.e., hospitals, job development and job placement programs, or low income housing). It may also include investing in programs which finance low cost mortgages and educational loans. As a socially responsible investor, you will be working to achieve your financial goals and have a positive influence.

---

*Jim Coffield and Todd Smurl are Financial Advisors with the Little Rock office of Prudential Securities Incorporated. Any opinions expressed in this article are those of the authors, and not those of Prudential Securities.*

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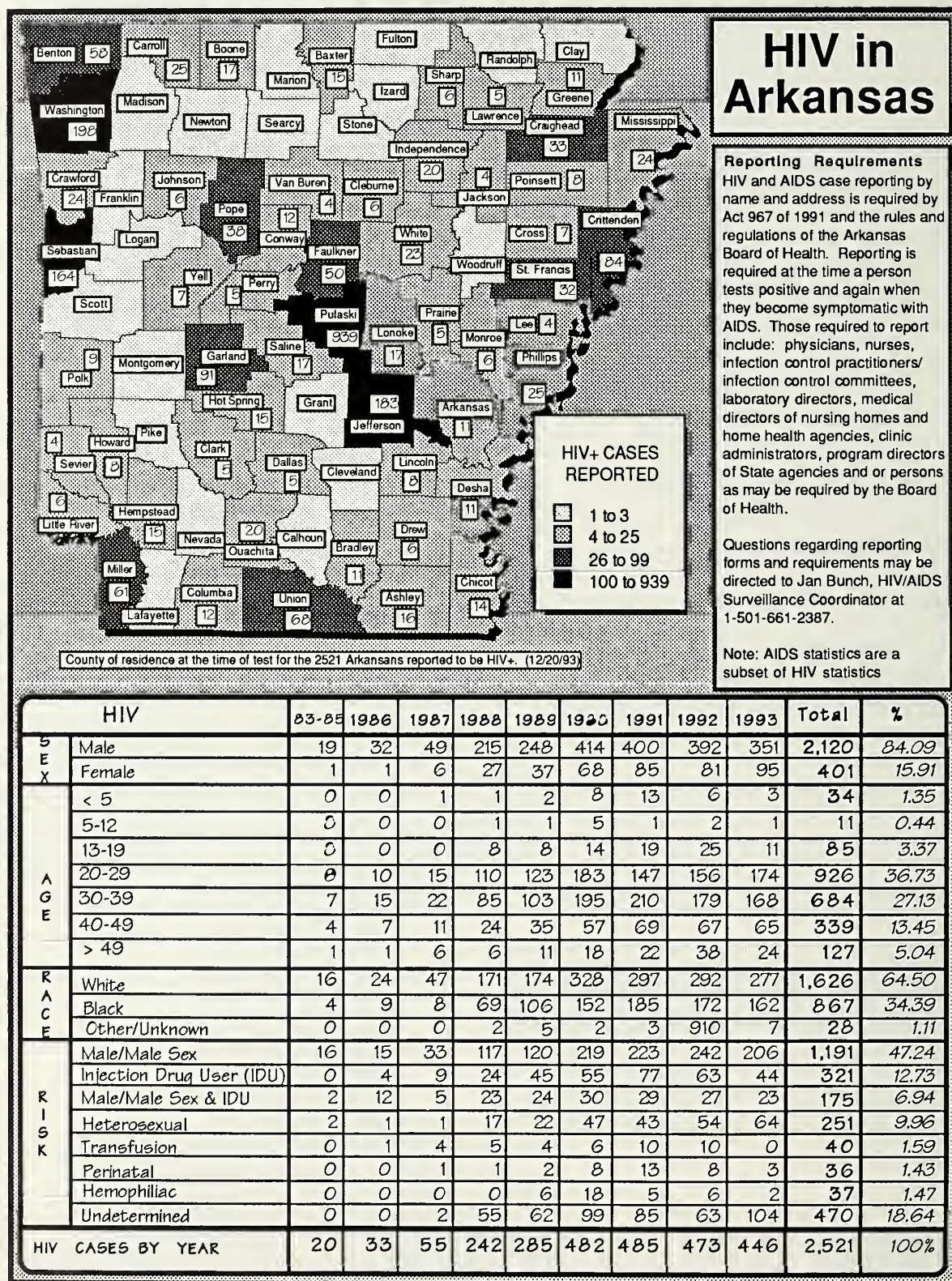
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# Arkansas HIV/AIDS Report 1983-1993

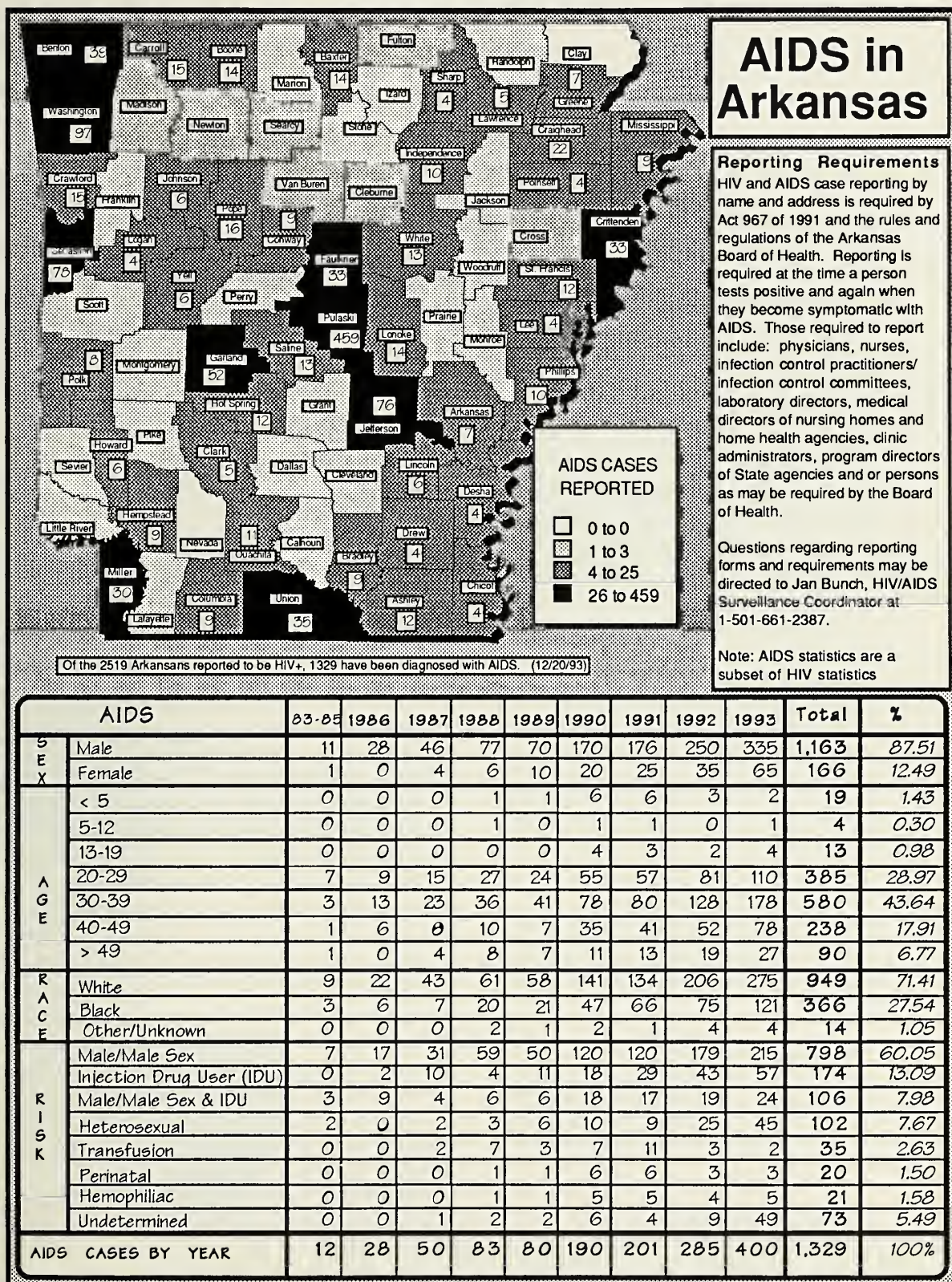


Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1993



Source: AIDS Surveillance Unit, Arkansas Department of Health.



# New Members

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## ARKADELPHIA

**Ferrari, Victor J.**, Radiology. Medical education, UAMS, 1957. Internship, UAMS, 1958. Residency, Travis Air Force Base, California, 1973. Board certified.

## ASHDOWN

**Swiney, Jennifer R.**, Internal Medicine. Medical education, University of Missouri Medical School, Columbia, Missouri, 1973. Internship/Residency, St. John's Mercy Med Center, 1978. Board certified.

## BENTON

**Schmidt, Michael J.**, Surgery. Medical education, University of Michigan, Ann Arbor, Michigan, 1978. Internship/Residency, St. Joseph Mercy Hospital, Ann Arbor, 1983. Board certified.

## BLYTHEVILLE

**Lowery, Russell C.**, Surgery. Medical education, Tulane Medical School, New Orleans, 1963. Internship/Residency, Charity Hospital, North Louisiana, 1970. Board certified.

## CAMDEN

**Martin, Dan A.**, Internal Medicine. Medical education, UAMS, 1979. Internship/Residency, UAMS, 1982. Board certified.

## CONWAY

**Ross, Rex W.**, Family Practice. Medical education, UAMS, 1972. Internship, St. Vincent Infirmary, Little Rock, 1973. Board certified.

## FAYETTEVILLE

**Cross, Michael J.**, Surgical/Oncology. Medical education, University of Nebraska, Omaha, 1987. Internship/Residency, Scott & White Hospital, Temple, Texas, 1992. Board certified.

## FORREST CITY

**Kumar, Sudhir**, Internal Medicine. Medical education, JJM Medical College, Dauangere, India, 1987. Internship/Residency, Catholic Medical Center, New York, 1993. Board certified.

## HEBER SPRINGS

**Sharp, Jan C.**, Family Medicine. Medical education, UAMS, 1989. Internship/Residency, UAMS, 1993. Board certified.

## HOT SPRINGS

**Jackson, Brian D.**, Allergy and Asthma. Medical education, American University of the Caribbean, 1988. Internship/Residency, St. Louis University, Missouri Deaconess Hospital, 1991. Board certified.

## JONESBORO

**Bryan, James E.**, Cardiology. Medical education, University of Missouri, Columbia, 1987. Internship/Residency, University of Missouri/Columbia Hospital and Clinics, 1990. Fellowship, University of St. Louis, 1993. Board certified.

**Hackbarth, Mark A.**, Anesthesiology. Medical education, Oral Roberts University, Tulsa, Oklahoma, 1982. Internship, University of Illinois, Chicago, 1983. Residency, Parkland, Dallas, Texas and University of Cincinnati, Ohio, 1993.

**Stroope, Henry F.**, Orthopaedic Surgery. Medical education, UAMS, 1987. Internship/Residency, 1992.

## LAKE VILLAGE

**Hill, Shirlene B.**, General Practice. Medical education, Oklahoma State University, Tulsa College of Osteopathic Medicine, 1991. Internship, Tulsa Regional Medical School, 1992.

## LITTLE ROCK

**Brewer, Thomas E.**, Nephrology. Medical education, University of Texas, Galveston, 1964. Internship/Residency, UAMS, 1968. Board certified.

**Campbell, Leah S.**, Psychiatry. Medical education, UAMS, 1983. Internship/Residency, St. Vincents Hospital, New York, 1987.

**Darwin, William G.**, Family Practice. Medical education, UAMS, 1959. Internship, San Francisco General Hospital, 1960. Little Rock VA Hospital, 1961. Board certified.

**Donovan, William F.**, Orthopedic Surgery/Industrial Medicine. Medical education, Loyola-Stritch School of Medicine, Chicago, 1968. Internship, Cook County Hospital, Chicago, 1969. Residency, Northwestern University, Chicago, 1973. Board certified.

**Malott, Jerry D.**, Internal Medicine. Medical education, UAMS, 1973. Internship/Residency, University Hospital/UAMS, 1976. Board certified.

**McMillan, James A.**, Internal Medicine & Addiction Medicine. Medical education, UAMS, 1973. Internship/Residency, University Hospital/UAMS, 1976. Board certified.



**Mehta, Madhu**, Internal Medicine. Medical education, Maulana Azad Medical College, New Delhi, India, 1985. Internship/Residencies, Maulana Azad Medical College, 1989. Safdarjung Hospital, New Delhi, India, 1990. Hurley Medical Center and UAMS.

**Teo, Charles**, Neurosurgery. Medical education, New South Wales, Australia, 1981. Internship, Repatriation General Hospital Concord, 1982. Residency, Royal Prince Alfred Hospital, 1990.

### **MOUNTAIN HOME**

**Beck, Dennis R.**, Anesthesiology. Medical education, Texas Tech University, Lubbock, 1984. Internship, St. Francis Hospital, Wichita, Kansas, 1985. Residency, University of Kansas at Wichita, 1991.

**Short, Luke H.**, Anesthesiology. Medical education, UAMS, 1986. Internship/Residency, Brooke Army Medical Center, San Antonio, Texas, 1990.

### **PINE BLUFF**

**Alexander, Lester T.**, Family Practice. Medical education, Meharry Medical College, Nashville, 1980. Residency, UAMS/AHEC-Pine Bluff, 1983.

**Rhode, Marvin C.**, Primary Care. Medical education, Jefferson Medical School, Philadelphia, 1947. Internship, Jewish Hospital, Philadelphia, 1948. Residency, State University of Iowa Hospitals, 1952. Board certified.

**Rowe, David E.**, Administrative. Medical education, Philadelphia College Osteopathic Medicine, 1961. Internship, Allentown Osteopathic Medical Center, 1962. Board certified.

### **SEARCY**

**Burns, Jerry A.**, OB/GYN. Medical education, UAMS, 1983. Internship/Residency, Tripler Army Medical Center, Honolulu, Hawaii, 1987. Board certified.

### **VAN BUREN**

**Flanagan, Mary C.**, Internal Medicine. Medical education, University of Florida, Gainesville, 1986. Internship/Residency, Indiana University, 1988. University of Tennessee, Knoxville, 1989. Board certified.

### **TEXARKANA**

**Chadalavada, Ramesh**, Pulmonary Disease & Internal Medicine. Medical education, Guntur Medical School, India. Internship/Residency, Cook County Hospital, Chicago, 1989. Fellowship, University of South Florida, Tampa, 1992. Board certified.

### **WEST MEMPHIS**

**Barr, Marian**, Internal Medicine. Medical education, Meharry Medical College, Nashville, 1979. Internship/Residency, Hubbard Hospital, Nashville, Tennessee, 1982.

### **OUT OF STATE**

**Schwartz, Joseph C.**, Ophthalmology. Medical education, University of Maryland, Baltimore, 1988. Internship, Mercy Medical Center, Baltimore, 1989. Residency, Washington Hospital Center, Washington, D.C., 1992. Board certified.

**Smith, Kirby L.**, Hematology/Oncology, Memphis, Tenn. Medical education, University of Tennessee Center for Health, Memphis, 1964. Internship/Residency, Barnes Hospital, St. Louis, Missouri, 1967.

### **RESIDENTS**

**Henry, Paul M.**, Ophthalmology. Medical education, University of Tennessee, Memphis, 1992. Internship, University of Tennessee, 1993. Residency, UAMS.



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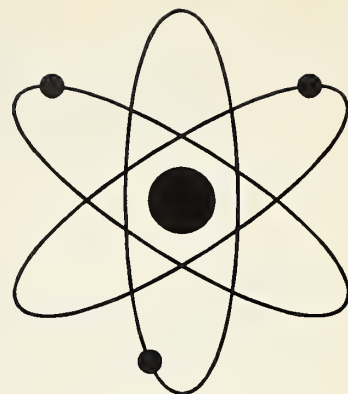
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# Radiological Case of the Month



Steven R. Nokes, M.D.  
William P. Fiser, M.D.  
John E. Hearnberger, M.D.

## History:

This elderly gentleman presented with severe, tearing chest pain. A plain chest x-ray revealed an ectatic thoracic aorta. A dynamic chest CT (Figure 1) and aortogram (Figure 2) were obtained.

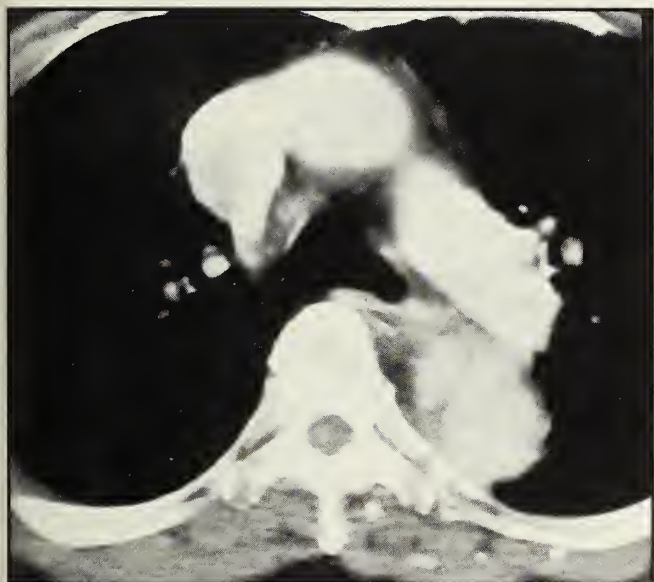


Figure 1: CT scan of the chest.

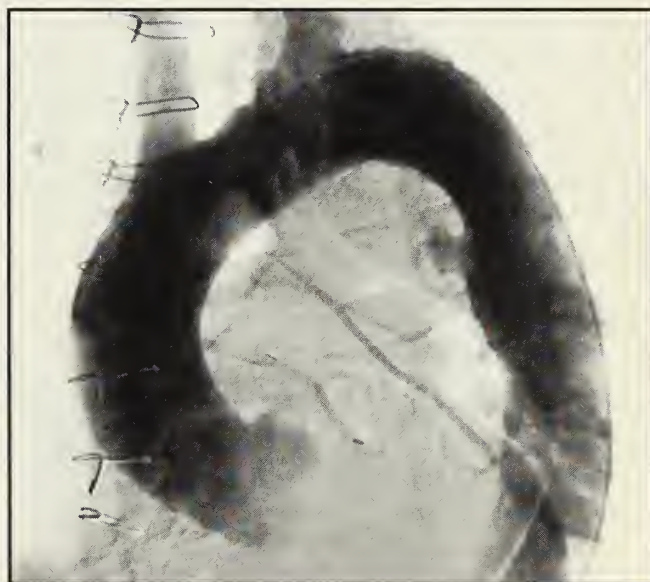


Figure 2: Arch aortogram.

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# Penetrating aortic atherosclerotic ulcer.

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## Findings:

CT reveals a focal ulcer of the upper descending thoracic aorta which projects medially. There is associated intramural hemorrhage. The aortogram demonstrates a mushroom shaped ulcer with smooth margins in the same location.

## Discussion:

Penetrating atherosclerotic ulcer is a recently described (1986) aortic catastrophe that clinically mimics aortic dissection. Classic aortic dissection begins with an intimal tear within the points of greatest hydraulic stress; the right lateral ascending aorta and near the ligamentum venosum in the proximal descending aorta. Pulsatile flow then splits the media forming smooth walled true and false lumens. In contrast, a penetrating atherosclerotic ulcer penetrates an area of atherosclerotic plaque and enters the media, where it can initiate hematoma formation, a false aneurysm (as in this case) or transmural rupture. Penetrating ulcers rarely occur in the ascending aorta or arch as these areas tend to be spared by atherosclerosis. They most commonly occur in the descending aorta and upper abdominal aorta.

Imaging allows distinction between the two entities. CT reveals a focal ulcer with subintimal hemorrhage often with medially displaced intimal calcification and thickening or enhancement of the aortic wall. These occur throughout the descending aorta. A dissection is characterized by a smoothly spiraling flap. Aortography mirrors the CT finding. MR can be used as the primary modality for studying suspected dissection and ulceration. It has the advantages of multiplanar imaging and does not require contrast, but costs more than CT and requires more time to perform. Transesophageal echocardiography may replace CT as the initial examination of choice where it is available.

Conservative antihypertensive therapy may be effective if the patient remains hemodynamically stable, but persistent or recurrent pain should prompt surgery. Surgical repair of a penetrating ulcer is difficult as the aorta is often friable and requires a fairly long graft. Type III aortic dissection requires surgical intervention less frequently and is usually less extensive.

## References

1. Kazerooni EA, Bree RL, Williams DM. Penetrating atherosclerotic ulcers of the descending thoracic aorta: evaluation with CT and distinction from aortic dissection. *Radiology* 1992; 183:759-765.
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3. Hussain S, Glover JL, Bree R, Benedick PJ. Penetrating atherosclerotic ulcers of the thoracic aorta. *J Vasc Surg* 1989; 9:710-717.

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*Editor: Steven R. Nokes, M.D., is affiliated with Radiology Consultants in Little Rock.*

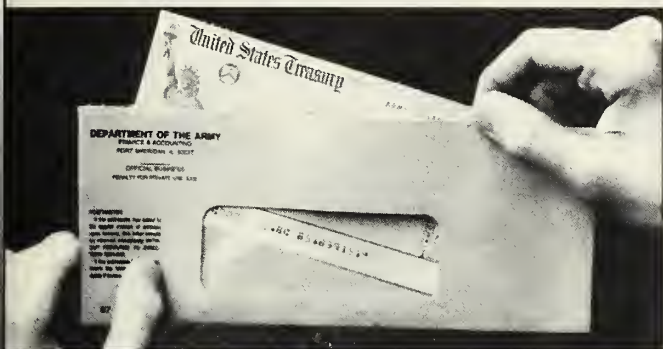
*Contributor: William P. Fiser, M.D., is affiliated with Cardiovascular and Thoracic Surgery in Little Rock.*

*Contributor: John E. Hearnberger, M.D., is affiliated with Cardiovascular and Thoracic Surgery in Little Rock.*



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# AMS Newsmakers

**Dr. John D. Ashley**, Newport, recently attended the 56th Annual Meeting of the American Physicians Art Association (APAA) in conjunction with the 87th Annual Scientific Assembly of the Southern Medical Association in New Orleans. Dr. Ashley, who also serves as Vice President of the APAA, won honorable mention for his art exhibit.

**Dr. James P. DeRossitt, III**, was one of nine Arkansas physicians to be initiated into the Fellows of the American College of Surgeons, the largest organization of surgeons in the world, during its 1993 Annual Clinical Congress.

**Dr. Robert Fisher** has been awarded a certificate of added qualifications in pain management by the American Board of Anesthesiology. He is affiliated with Holt-Krock Clinic.

**Dr. Geoffrey Goldsmith**, chairman of the Department of Family and community Medicine at the University of Arkansas for Medical Sciences in Little Rock, has been appointed to the Bureau of Health Professions Rural Health Medical Education Program. The first person in the state of Arkansas to be appointed to this program, Goldsmith will review grant applications for model primary-care residency education programs linked with rural hospitals.

**Dr. Frederick Guggenheim**, of the University of Arkansas for Medical Sciences, was recently asked by Donna Shalala, secretary of the U.S. Health and Human Services Department to serve a three-year term on a national council.

Dr. Guggenheim, chairman of the Department of Psychiatry and Behavioral Sciences at UAMS, is one of only two physicians appointed to the 12-member committee, known as the Substance Abuse and Mental Health Service Administration National Advisory Council.

**Dr. Gerald L. Guyer** of Stuttgart received a direct commission recently as a Lieutenant Colonel in the U.S. Air Force during a ceremony held at Little Rock AFB in Jacksonville.

Guyer is a family practice physician who had worked at the Stuttgart Medical Clinic since 1974. Prior to moving to Stuttgart, he served as an Air Force doctor for three years.

**Dr. H.V. Kirby**, who served as an Army captain in World War II and was awarded the Bronze Star in Italy, was honored by a special tribute in the just-published, year-end edition of the "Boone County Historian," in Harrison. The sterilizer he used during those days is on display in the Medical Room of the Boone County Heritage Museum.

**Dr. Diane Lepore**, medical director for Northeast Arkansas Rehabilitation Hospital, recently was elected vice-president of the Arkansas Society of Physical Medicine and Rehabilitation.

**Dr. Hampton Roy** has recently published an article describing a new technique for cataract surgery in the December 1993 issue of Ophthalmology Times.

The article described a technique of ocular topical anesthesia in the I.V. medication is given, but no shots are used around the eye. Diamond blades are used to make a small beveled corneal incision that usually do not require a suture to close the wound. This procedure avoids the vascular elements, and therefore the patients may continue aspirin, coumadin and other blood thinners around the time of surgery.

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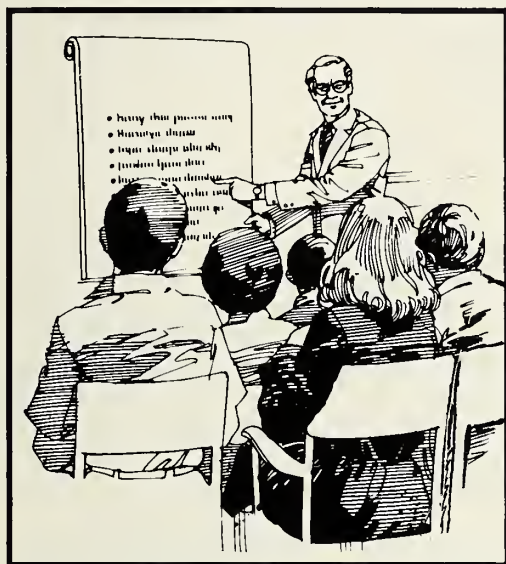
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# Medical Students in the News



The Arkansas Medical Society would like to congratulate the following medical student members who have recently been awarded scholarships:

**Charolette Coleman**, UAMS senior medical student from Huntsville, is the recipient of the 1993-94 Dr. and Mrs. William Robert Orr, Sr. Medical Missionary Scholarship. The presentation of the scholarship was made at the annual College of Medicine Scholarship Banquet by Dr. I. Dodd Wilson, dean of the College of Medicine.

**Tim Goodson** of Arkadelphia has been named by the University of Arkansas for Medical Sciences, College of Medicine as the recipient of the inaugural John Samuel Taylor Memorial Scholarship. This scholarship was established by Dr. and Mrs. George D. Taylor of Arkadelphia, as well as family and friends of the Taylors, in memory of their son, John Samuel Taylor.

**Minor Gregory** from Augusta, sophomore medical student at UAMS, has been named the 1993-94 recipient of the Dr. and Mrs. Frank Maguire, Sr., Scholarship. The scholarship was established in 1966 by anonymous donors to honor Dr. Maguire and his wife, who served the Augusta area through many civic activities.

**Martin Siems**, a senior medical student from Scott, has been awarded the Dr. James Gentry Thomas Memorial Scholarship for 1993-94 at UAMS. The scholarship is awarded annually to a senior medical student who has demonstrated superior academic achievement.

**Kristin Steingraber** of Jonesboro has been awarded the annual Northeast Arkansas Internal Medicine Clinic of Jonesboro scholarship for 1993-94 at UAMS. The scholarship is paying full tuition for her freshman year of medical school.

**Jim Wood** of Tupelo received a Dorothy Snider Foundation Scholarship for the 1993-94 school year. Dr. I. Dodd Wilson, dean for the College of Medicine, made the formal presentation at the annual College of Medicine Scholarship Banquet.



## Health Care Access Foundation Update

As of January 1, 1994, the Arkansas Health Care Access Foundation has provided free medical service to 6,991 medically indigent persons, received 13,372 applications, and enrolled 27,139 persons.

The program has 1,641 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

## Med-Ed Program Addresses Shortage of Doctors

Using a similar concept that brought Dr. Joel Flieshman to a small Alaskan town in the television show Northern Exposure, members of a community-based organization and Baptist Memorial Hospitals of Mississippi County are trying to address the need for doctors in this predominately rural area.

Members of the Mississippi County Medical Education Council, Med-Ed, have created a program that will offer any medical student a full scholarship (including living expenses) in exchange for an obligation to practice in Mississippi County upon graduation.

The organization consists of a variety of community leaders through Mississippi County. They have already raised \$155,000 without undertaking a single fund-raising effort. All money raised will reportedly be matched by Baptist Hospitals.

The Mississippi County Community Foundation, in cooperation with Med-Ed, has already hired Linda Goldsmith, the former director of the state office on rural health, to conduct a needs assessment study of Mississippi County in order to create a brochure to be used in future fund-raising efforts.

Any medical student is eligible for the scholarship with the only requirement at present being the commitment to practice (one year for every year of scholarship) and obtaining a medical license to practice in Arkansas.

To address the immediate need for a doctor in this area, Med-Ed is could purchase the debt of a doctor that has already graduated medical school.

Officials representing Med-Ed and the Baptist Memorial Hospitals of Mississippi County also announced a verbal commitment from the University of Arkansas School of Medicine to make the county's two hospitals part of the statewide AHEC program.

## New Claim Form for CHAMPUS Coming Soon

CHAMPUS will soon replace its standard patients' claim form in the U.S. and Puerto Rico with a new, simpler version. The new form, "Patient's Request for Payment" (DD Form 2642), will eventually replace the current CHAMPUS claim form, the DD Form 2520. The old form will continue to be used overseas, and may be used in the U.S. until it is declared obsolete, or until supplies run out, whichever occurs first.

The new, simplified claim form is only half the length of the old one and doesn't need a provider's signature (providers of care who send in CHAMPUS claims on behalf of patients must use the HCFA Form 1500 or the UB-92 form). Patients will just fill in a few simple blocks of information, provide other health insurance information, attach copies of the medical bills to the form, and send it to the appropriate CHAMPUS claims processing contractor.

## Providers Check "Yes", Agree to Participate in CHAMPUS

When a health care provider checks the "yes" block on the current CHAMPUS claim form (DD Form 2520) and signs the claim, he or she is agreeing to "participate" (or, "accept CHAMPUS assignment") on the claim. This means that the claims processor will send payment directly to the provider. The provider agrees to accept what CHAMPUS pays, plus the patient's cost-share, as full payment for covered services. The patient is responsible for only his or her share of the cost (plus the cost of any services that aren't covered by CHAMPUS), and the provider may not bill the patient for the difference between the amount allowed on the claim and the billed charges.

A provider who violates the agreement to participate (accept assignment) on a claim by billing the patient for the difference between the amount allowed and the billed charges is subject to penalties under CHAMPUS rules, including withdrawal of program approval as a CHAMPUS provider and possible recoupment of payments made by CHAMPUS.

By the same token, a provider is required to collect the patient's cost-share, since it is established by law. Providers who routinely waive patient cost-shares may be suspended as CHAMPUS-authorized providers and may face punitive action.



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\*Immediate opening available.

# Things To Come

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## March 10-11

**Refresher Course and Update in Gastrointestinal Surgery.** The Ritz-Carlton Hotel, St. Louis, Missouri. Sponsored by the Washington University School of Medicine. For more information call (800) 325-9862.

## March 11-13

**Medical Review Officer.** Marina Del Rey Ritz Carlton, Marina Del Rey, California. Presented by the American Society of Addiction Medicine. For more information, call (202) 244-8948.

## March 12

**Medical Management of the Atherosclerosis Plague.** Inforum - Atlanta Market Center, Atlanta, Georgia. No fee. For more information, call Todd D. Belfield, George Washington University Medical Center, (202) 994-4285.

## March 12-13

**Laparoscopy in Urologic Surgery: Radical Perineal Prostatectomy.** Tulane University Medical School. Category I credit: 12.5 hours. Sponsored by the Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## March 17-19

**Human Genetics in Clinical Practice.** Holiday Inn Superdome, New Orleans. Sponsored by the Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## March 17-20

**California Medical Association's Western Scientific Assembly.** Disneyland Hotel, Anaheim. For more information, call (415) 882-3384.

## March 18

**Ultrasound in Abdominal Surgery.** Ross Hall, The George Washington Univ. Medical Center, Washington, D.C. For more information, call Maria Gorrick, George Washington University Medical Center, (202) 994-4285.

## April 6-8

**Temporomandibular Joint Update.** Silverado Resort, Napa, California. Sponsored by the UC Davis Medical Center, Office of CME. For more information, call (916) 734-5390.

## April 15-17

**44th Annual Postgraduate Symposium on Anesthesiology.** Ritz-Carlton Hotel, Kansas City, Missouri. For more information, call the University of Kansas Medical Center Office of Continuing Education, (913) 588-4490.

## April 16-22

**79th Annual American Occupational Health Conference.** Hyatt Regency Chicago. For more information, call the American College of Occupational and Environmental Medicine, (708) 228-6850.

## April 21-22

**Prescription for the Future: What Way Health Reform? (a Managed Care Symposium).** Le Meridien Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call Office of CME, (504) 588-5466 or (800) 588-5300.

## April 21-23

**Pain and Pain Management.** Radisson Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call Office of CME, (504) 588-5466 or (800) 588-5300.

## April 27-28

**State of the Art of Prevention of Heart Disease.** Westin Canal Place Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call Office of CME, (504) 588-5466 or (800) 588-5300.

## April 28-30

**Federation of State Medical Boards Annual Meeting.** Grand Hyatt, Washington, D.C. For more information, call George Washington University Medical Center, (202) 994-4285.

## April 28-30

**Primary Care Symposium III.** Hotel Intercontinental, New Orleans. Sponsored by the Hispanic/American Medical Association of Louisiana and the Tulane University Medical Center. For more information, call Office of CME, (504) 588-5466 or (800) 588-5300.

## April 29-30

**Current Topics in Pathology IV: Hematopathology.** Westin Canal Place Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.



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(501) 221-3033  
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**Arkansas Health Care  
Access Foundation, Inc.**

## **Symposium on Critical Care and Emergency Medicine**

*April 7-9, 8:15 a.m., Arlington Hotel and Resort Spa, Hot Springs. Sponsored by UAMS College of Medicine and presented by Terry Yamauchi, M.D. & Milton Deneke, M.D. Fee: \$200.*

## **Management of Dementias in the Elderly**

*April 13, time to be announced, Excelsior Hotel, Little Rock. Sponsored by UAMS College of Medicine and presented by David A. Lipschitz, M.D. and Ronnie Chernoff, Ph.D. Fee: approximately \$100.*

## **Advances in the Diagnosis and Management of Breast Cancer**

*April 14-16, 7:30 a.m., registration and continental breakfast, Statehouse Convention Center, Little Rock. Spon-*

*sored by UAMS and the American Cancer Society. Presented by Suzanne Klimberg, M.D. Category I credit 13.5 hours. Fee: \$300 for physicians. For more information, call 686-6503.*

## **Arkansas Perinatal Association**

*April 18, time and location to be announced. Sponsored by UAMS College of Medicine and presented by Russell Kirby, M.D.*

## **W.W. Stead Chest Symposium**

*April 23, time to be announced, Holiday Inn-City Center, I-630 & Broadway, Little Rock. Sponsored by UAMS College of Medicine and presented by Marcia Erblan M.D.*

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **FAYETTEVILLE-VA MEDICAL CENTER**

*General Medical Topics, Thursdays, 12:00 noon, Auditorium, Bldg. 3  
Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*Continuing Medical Education Luncheon, Feb. 25, Mar. 11 & 25, Apr. 8 & 22, 12:30 p.m., AMI Ozark - Quapaw Room*

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom*

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Cancer Conferences, Thursdays, 12:00 noon, location to be announced. Lunch provided.  
Chest Conference, 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.  
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Mental Health Conference, 3rd Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided*



## **LITTLE ROCK-BAPTIST MEDICAL CENTER**

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., Conference Room 1  
Breast Conference, 3rd Thursday, 7:00 a.m., Conference Room 1  
GI Conference, 4th Friday, 11:30 a.m., Conference Room 1  
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library  
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

## **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

Chest & Problems Case Conference, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
Medicine Conference, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
Surgery Conference, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06  
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06  
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
Cardiothoracic Surgery Conference, date, time, & location varies  
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
CME Outreach Program, dates, times & locations vary  
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC  
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33  
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C  
Neurosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102

*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GRECC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

#### **EL DORADO-AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

#### **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

#### **FORT SMITH-AHEC**

*Advances in Plastic Surgery*, Monday, June 5, 8 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Tuesdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center



## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Harris Hospital Tumor Conference*, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

## **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, every other 3rd Wednesday, 12:30 p.m., St. Michael Hospital  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Residency Noon Conference*, Tuesdays, Wednesdays and Thursdays, 12:30 p.m., AHEC-Southwest Family Practice Clinic  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Board*, Fridays, except 5th Friday, 12:00 noon, Wadley Regional Medical Center & St. Michael Hospital  
*Tumor Conference*, every 5th Friday, 12:00 noon alternates between Wadley Regional Medical Center & St. Michael Hospital  
*AHEC Tumor Board*, 1st - 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital



# Advertisers Index

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*The Journal of the Arkansas Medical Society* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by the contributors.

All manuscripts should be submitted to Cindy Sawrie, Managing Editor, Arkansas Medical Society, P.O. Box 5776, Little Rock, Arkansas 72215. A transmittal letter should accompany the article and should identify one author as the correspondent and include his/her address and telephone number.

## MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

Along with the typed manuscript, we encourage you to submit an IBM-compatible 5 1/4" or 3 1/2" diskette containing the manuscript in ASCII format. The manuscript on diskette must be in the same format as stated above. We will return the diskette upon request.

## REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the author(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

## ILLUSTRATIONS

Illustrations should be professionally drawn and/or photographed. Glossy black and white photos are preferred. They should not be mounted and should have the name of the author(s) and figure number penciled lightly on the back. An arrow should indicate the top of the illustration. In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material. Up to four illustrations will be accepted at no charge to the author(s). If more than four are necessary, it is understood that the author(s) will be responsible for the reproduction costs.

## REPRINTS

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THE BASES ARE LOADED



## AMS' at Bat

118TH ANNUAL SESSION ☉ APRIL 7-9, 1994

EXCELSIOR HOTEL ☉ STATEHOUSE CONVENTION CENTER  
LITTLE ROCK, ARKANSAS

# THE BASES ARE LOADED

April 7-9, 1994  
118th AMS Annual Session  
Excelsior Hotel • Statehouse Convention Center  
Little Rock, Arkansas

## Thursday, April 7, 1994

- 9:00 a.m. Golf Tournament  
*Contribution made by Schering Corporation*
- 1:00 p.m. Registration Opens
- 2:00 p.m. Council Meeting
- 3:30 p.m. Welcome Reception  
*Sponsored by Worthen National Bank*  
*Exhibits Open*
- 5:00 p.m. First House of Delegates  
*AMA Address:*  
Donald T. Lewers, M.D.  
AMA Board of Trustees  
Easton, Maryland  
*Keynote Address:*  
Michael F. Staley  
Port Orange, Florida  
*Educational grant graciously provided by*  
*Freemyer Collection System*
- 6:30 p.m. Blue Cross Blue Shield Reception

## Friday, April 8, 1994

- 7:30 a.m. Council Meeting
- 8:30 a.m. Continental Breakfast  
*Sponsored by First Commercial Bank*  
*Exhibits Open*
- 9:30 a.m. Reference Committees
- 11:00 a.m. First Feature Session  
"Coping with the New Managed  
Care Paradigm"  
Alice G. Gosfield, J.D.  
Philadelphia, Pennsylvania
- 12:30 p.m. Shuffield Lecture/Luncheon  
"The Challenges in Health Care Reform"  
Mark V. Pauly, Ph.D.  
Philadelphia, Pennsylvania  
*Contribution made by Rebsamen*  
*Insurance/CNA Insurance*
- 2:15 p.m. Second Feature Session  
"Trends and Prospectives on National  
Health Care Reform"  
William D. McInturff  
Washington, D.C.
- 3:30 p.m. Afternoon Break  
*Contributions made by Metropolitan National Bank*  
*and Professional Consulting Services, Inc.*  
*Exhibits Open*
- 6:00 p.m. Wine & Cheese Party for Young Physicians  
*Sponsored by AMS Benefits, Inc.*
- 7:00 p.m. "Grand Slam Celebration"  
Entertainment: "The GroanUps"

## Saturday, April 9, 1994

- 7:30 a.m. Council Meeting
- 8:00 a.m. Early Morning Refreshments  
*Sponsored by State Volunteer Mutual*  
*Insurance Company*
- 8:45 a.m. 6th AMS AIDS Seminar  
Robert R. Redfield, M.D.  
Rockville Maryland
- 10:30 a.m. Final House of Delegates
- 12:30 p.m. Fifty Year Club Luncheon  
*Sponsored by Communi-care/Pro-Rehab*  
Specialties/Committees can elect to meet
- 12:30 p.m. AIDS Mini-Session  
*Educational grant graciously provided by*  
*Burroughs Wellcome Co.*
- 6:00 p.m. Hospitality Hour  
*Sponsored by American Health Care*  
*Providers, Inc.*
- 7:00 p.m. Inaugural Banquet  
Entertainment: "A Magical Evening"  
Andy L. Hickman
- 9:00 p.m. President's Dessert Reception  
*Contribution made by St. Paul Fire and Marine*  
*Insurance Company*



# AMS' at Bat



# Arkansas Medical Society 1994 Convention Keynote Speakers

## Keynote Address

Michael F. Staley, an award-winning fire fighter who was injured when a race car careened out of control at the Daytona International Speedway, will be the keynote speaker at the opening session, Thursday, April 7 at 5:00 p.m. His story, featured on Rescue 911, will impact you as he relates "Ten Things Your Patients Never Told You."



## Shuffield Lecture

Mark V. Pauly, Ph.D., will address "The Challenges in Health Care Reform," at the Shuffield Lecture on Friday, April 8 at 12:30 p.m. He will discuss some of the misconceptions and hard realities surrounding health care reform. Dr. Pauly is Director of Research and Senior Fellow at the Leonard Davis Institute of Health Economics.

He will discuss some of the misconceptions and hard realities surrounding health care reform. Dr. Pauly is Director of Research and Senior Fellow at the Leonard Davis Institute of Health Economics.



## 1st Feature Session

Alice G. Gosfield, J.D., from Philadelphia, will address "Coping with the New Managed Care Paradigm" at the First Feature Session on Friday, April 8 at 11:00 a.m. She will discuss the structure of medical practice in the managed care environment. Ms. Gosfield has restricted her practice to health law and health care regulations since 1973.

She will discuss the structure of medical practice in the managed care environment. Ms. Gosfield has restricted her practice to health law and health care regulations since 1973.

## 2nd Feature Session

William D. McInturff is co-founder of Public Opinion Strategies, one of Washington's most respected survey and research strategy organizations. He will address the "Trends and Prospectives on National Health Care Reform," Friday, April 8, 2:15 p.m. He specializes in tracking current trends in both the public and legislative perspectives of health care reform.

He specializes in tracking current trends in both the public and legislative perspectives of health care reform.



## 3rd Feature Session

Robert R. Redfield, M.D., of the Department of Retroviral Research at Walter Reed Army Institute of Research in Rockville, Maryland, will speak at the 6th AMS AIDS Seminar on Saturday, April 9, 8:45 a.m. Dr. Redfield will give his thoughts on HIV disease and results of his vaccine research. He was among those who first reported on the detection, isolation and characterization of HIV-1.

isolation and characterization of HIV-1.

## AIDS Mini Session

Local physicians will lead workshops covering different educational topics such as anti-viral therapy, when to use certain drugs, and women and HIV. The mini session will be on Saturday, April 9, 1:00 p.m.-3:00 p.m. The AIDS mini-session program is open to physicians and other health care personnel interested in current treatment and clinical management of patients with HIV.



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# 70th Alliance Annual Session

April 7-9, 1994

Excelsior Hotel • Statehouse Convention Center  
Little Rock, Arkansas

## AMS Alliance Meeting At a Glance

### Thursday, April 7

- |           |                                   |
|-----------|-----------------------------------|
| 1:30 p.m. | Pre-convention Board Meeting      |
| 3:30 p.m. | Welcome Reception - Exhibits Open |
| 5:00 p.m. | AMS Keynote Address               |
| 6:30 p.m. | Blue Cross Blue Shield Reception  |

### Friday, April 8

- |            |  |
|------------|--|
| 8:00 a.m.  | Past Presidents' Breakfast               |
| 8:30 a.m.  | Continental Breakfast - Exhibits Open    |
| 9:00 a.m.  | Alliance Opening General Session         |
| 11:00 a.m. | AMS First Feature Session                |
| 12:30 p.m. | Shuffield Lecture & Luncheon             |
| 2:15 p.m.  | AMS Second Feature Session               |
| 3:30 p.m.  | Alliance Second General Session          |
| 6:00 p.m.  | Wine & Cheese Party for Young Physicians |
| 7:00 p.m.  | AMS Grand Slam Celebration               |

### Saturday, April 9

- |            |                                     |
|------------|-------------------------------------|
| 8:00 a.m.  | Early Morning Refreshments          |
| 8:30 a.m.  | One on One with Darlene Young, AMAA |
| 9:15 a.m.  | Alliance Third General Session      |
| 12:00 p.m. | Installation Luncheon and Awards    |
| 6:00 p.m.  | AMS Hospitality Hour                |
| 7:00 p.m.  | AMS Inaugural Banquet               |
| 9:00 p.m.  | AMS President's Dessert Reception   |



**DARLENE YOUNG**, Secretary  
American Medical Association  
Alliance, Inc.

Darlene Young, of Greensboro (Guilford County), N.C., was elected 1993-94 Secretary of the American Medical Association Alliance at the 1993 Annual Session. She also is a member of the Bylaws Committee. Mrs. Young has served at the national level as field director, southern regional director, chairman and member of the Long-Range Planning Committee, a member of the Health Projects Committee, and a member and chairman of the Election Committee. Mrs. Young has served her state Alliance as president, president-elect, parliamentarian, corresponding secretary, consultant and awards chairman, and currently is Finance Committee chairman. She has also been involved in a variety of other volunteer efforts, including serving as a member of the Governor's Task Force on Domestic Violence, president of the Greensboro Symphony Guild and more.

# General Information

## Registration and Fees

The convention registration desk will be located in the Osage Room of the Statehouse Convention Center and will be staffed during the following times:

Thursday, April 7 1:00 p.m. - 5:00 p.m.  
Friday, April 8 7:30 a.m. - 4:30 p.m.  
Saturday, April 9 8:00 a.m. - 2:00 p.m.

No person will be admitted to any activity of the annual session without first registering. Upon checking in at the convention registration desk, you will receive a convention program, your name badge, tickets for meals and social functions, and other convention material.

	Pre-registration	On-site Registration
Member	\$75.00	\$90.00
Spouse	\$55.00	\$70.00
Clinic Manager	\$75.00	\$90.00
Non-member	\$110.00	\$125.00

*AMS Past Presidents receive \$25.00 discount.*

Resident	\$5.00	\$10.00
Student	\$5.00	\$10.00
Spouse	\$5.00	\$10.00

Resident and Student fees do not include Inaugural Banquet tickets, which can be purchased at \$35.00 per person.

## Telephone Service

The Society will have a convention telephone at the registration desk during registration hours for your convenience. Call the **Statehouse Convention Center** at (501) 376-4781, extension 1024. You may leave this number with your office personnel in case of emergencies.

## Cancellation Policy

All cancellations must be made in writing and received by April 1, to receive a refund. All refunds, minus a \$10 processing fee, will be mailed after the conference. No refunds will be given for cancellations after April 1. No refunds will be given on site.

## Exhibits

Commercial exhibits will be on display in Governor's Hall I in the Statehouse Convention Center. Dr. R. Jerry Mann, Annual Session chairman, urges all members to take the time to visit the displays. The exhibits are a part

of the educational program of the convention and provide members with the latest information on progress in pharmaceutical research, insurance, accounting systems, computers, investments, and other new products and services available. **Exhibit hours** are the following

Thursday, April 7: 3:30 p.m. - 5:00 p.m.  
Friday, April 8: 8:30 a.m. - 10:45 a.m.  
3:00 p.m. - 5:00 p.m.

## Convention Officials

R. Jerry Mann, M.D., Little Rock, chairman  
Glen F. Baker, M.D., Little Rock, AMS president  
James M. Kolb Jr., M.D., Russellville, AMS president-elect  
Mrs. Arleta Power, Little Rock, convention chairman, AMS Alliance

## Target Audience

This meeting is designed primarily for Arkansas physicians concerned with health care issues that affect the practice of medicine. Clinic managers, medical students, residents and other health care professionals will also benefit from this program.

## Program Objectives

- \*Give health care professionals the chance to network and exchange ideas.
- \*Update attendees on the trends, perspectives and challenges of health care reform.
- \*Explain the structure of medical practice within the managed care environment to include contracting, patient access and coordination of medical needs.
- \*Discuss vaccine research as well as social and economic issues associated with HIV disease.
- \*Provide health care professionals current and useful information about clinical management of patients with HIV and AIDS.

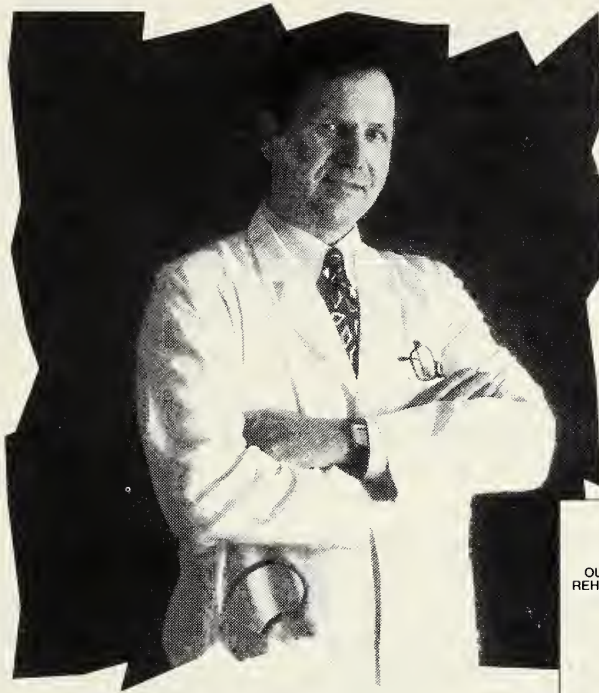
## Continuing Medical Education Credit

Baptist Medical Center is accredited by the Arkansas Medical Society to sponsor continuing medical education for physicians. Baptist Medical Center designates this continuing medical education activity for 6.5 credit hours in Category I of the Physicians Recognition Award of the American Medical Association. This program has been reviewed for and is acceptable for up to 5.5 hours of prescribed credit by the American Academy of Family Physicians.

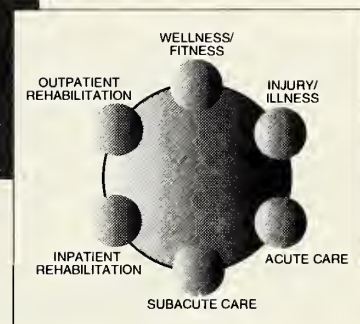
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# Young Physician Activities

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The Young Physician's Committee has planned several activities during the convention in order that members might network with other young physicians throughout the state.

A **Wine and Cheese Party** for young physicians will be hosted by **AMS Benefits, Inc.** at 6:00 p.m. on the Balcony (Ballroom Level) of the Excelsior Hotel.

Dr. Anna Ridling, Chairman of the Young Physician's Committee, encourages physicians to come to the Wine and Cheese Party and then attend to the "Grand Slam Celebration" featuring The GroanUps,

which begins at 7:00 p.m. in Salon C of the Excelsior Hotel (Ballroom Level). Dress is casual.

On Saturday, April 9, the Young Physician Section will meet at 12:30 p.m. in the Caraway Room I of the Statehouse Convention Center to consider plans for 1994. The Young Physician Section is any physician under the age of 40 or in practice five years or less.

The Committee would like to network with other young physician sections in nearby states and work more closely with the AMS Medical Student and Resident Physician Sections.

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## Specialty Meetings

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**Arkansas Academy of Family Physicians** will have a luncheon meeting on Saturday, April 9 from 12:30 - 3:30 p.m. in Salon C of the Excelsior Hotel.

**Arkansas Pathology Society** will have a luncheon meeting on Saturday, April 9 in the Caraway III Room at the Statehouse Convention Center from 12:30 p.m. - 3:00 p.m.

**Arkansas Society of Plastic & Reconstructive Surgeons** will meet on Saturday, April 9 in the Quapaw

Room of the Statehouse Convention Center beginning at 1:00 p.m.

**Arkansas Psychiatric Society** will meet Saturday, April 9 in the Caraway II Room at the Statehouse Convention Center from 12:30 p.m. - 2:00 p.m.

**Arkansas Urologic Society** will have a luncheon meeting on Saturday, April 9 in the LaSalle Room of the Excelsior Hotel from 12:30 p.m. - 2:30 p.m.

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## Fifty Year Club Luncheon

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The Society will host a luncheon for members of the Fifty Year Club at 12:30 p.m., Saturday, April 9, in the River Valley Room of the Excelsior Hotel. The Fifty Year Club Luncheon is sponsored by **Communi-care Pro-Rehab, Inc.**

Physicians eligible for the Fifty Year Club this year are:

R. Fred Broach, Little Rock  
W. Ely Brooks, Mt. Pleasant, SC  
Robert S. Cohen, Jonesboro  
Marion S. Craig, Jr., Little Rock  
C. Randolph Ellis, Malvern  
Guy R. Farris, Jr., Little Rock  
L. Fred Gordy, Conway  
James Guthrie, Camden  
Henry G. Hearnberger, Jr., Little Rock  
J. Forrest Henry, Little Rock  
Robert L. Henry, Jr., Little Rock  
Jack M. Irvin, Sheridan  
Gilbert D. Jay, III, Heber Springs

W. Payton Kolb, Little Rock  
Ralph G. Kramer, Fort Smith  
Charles S. Lane, Fort Smith  
William R. Lee, Hot Springs  
C. C. Long, Fort Smith  
Louis R. McFarland, Hot Springs  
Walter H. O'Neal, Little Rock  
Gordon P. Oates, Little Rock  
Cecil W. Parkerson, Hot Springs  
Charles G. Pearce, Clinton  
W. T. Rainwater, Jonesboro  
Ewing C. Reed, Jr., Little Rock  
George G. Regnier, Mountain Home

Henry N. Rogers, Mena  
Joseph L. Rosenzweig, Hot Springs  
Joseph Shelton, Jr., Ashdown  
Calvin R. Simmons, Pine Bluff  
N. Henry Simpson, Jr., Little Rock  
Norman K. Smith, Little Rock  
William B. Stanton, Pharr, TX  
Charles A. Taylor, Batesville  
Walter L. Walker, Brinkley  
H. Wendell Ward, Fayetteville  
John Watkins, Jr., Little Rock  
Walter J. Wilkins, Pine Bluff  
John P. Wood, Mena



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# House of Delegates

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The opening session of the House of Delegates of the Arkansas Medical Society will begin at 5:00 p.m. on Thursday, April 7. Speaker of the House John Crenshaw, M.D., will preside, assisted by Vice Speaker Brenda Powell, M.D.

All items of business to be considered by the House must either be printed in the convention issue of *The Journal* or submitted to the headquarters office in writing 20 days prior to the meeting. Any new business proposed during the session of the House of Delegates must have a two-thirds vote of attending delegates for introduction.

Items of business will be referred by the Speaker of the House of Delegates to one of two reference committees. Open hearings on those items of business will be held by the reference committees on Friday, April 8 at 9:30 a.m. All members of the Society are welcome to attend the meetings of the reference committees and to express views on the various reports, resolutions, etc.

The following will be seated at the House of Delegates meeting during the 1994 Annual Session:

## Officers

John Crenshaw, Pine Bluff, speaker, (ex-officio)  
Brenda Powell, vice speaker, (ex-officio)  
Glen F. Baker, Little Rock, president (ex-officio)  
James M. Kolb Jr., M.D., Russellville, president-elect  
(ex-officio)  
Gary L. Beville, M.D., El Dorado, vice president  
(ex-officio)  
Charles H. Rodgers, Little Rock, secretary (ex-officio)  
Lloyd Langston, M.D., Pine Bluff, treasurer (ex-officio)

District 10: Morton C. Wilson, Fort Smith  
Gerald A. Stolz, Russellville  
Paul Wills, Fort Smith

## Past Presidents (ex-officio)

Charles R. Henry Sr., Little Rock  
Joe Verser, Harrisburg  
C. Randolph Ellis, Malvern  
Joseph A. Norton, Little Rock  
H. W. Thomas, Dermott  
Ross E. Fowler, Harrison  
C. Stanley Applegate Jr., Springdale  
C. Robert Watson, Little Rock  
John P. Wood, Mena  
Ben N. Saltzman, Little Rock  
T.E. Townsend, Pine Bluff  
Albert S. Koenig Jr., Fort Smith  
W. Payton Kolb, Little Rock  
George F. Wynne, Warren  
A.E. Andrews Jr., Texarkana  
Kemal E. Kutait, Fort Smith  
Purcell Smith Jr., Little Rock  
Morriss M. Henry, Fayetteville  
Asa A. Crow, Paragould  
Charles F. Wilkins Jr., Russellville  
John P. Burge, Lake Village  
C.C. Long, Fort Smith (honorary)  
Ken Lilly, Fort Smith  
W. Ray Jouett, Little Rock  
John M. Hestir, DeWitt  
James R. Weber, Jacksonville  
William N. Jones, Little Rock  
George Warren, Smackover  
J. Larry Lawson, Paragould

## Councilors

District 1: Dwight Williams, Paragould  
Don B. Vollman, Jonesboro  
District 2: Michael Moody, Salem  
Lloyd Bess, Batesville  
District 3: Hoy B. Speer Jr., Stuttgart  
P. Vasudevan, Helena  
District 4: Paul A. Wallick, Monticello  
Anna T. Ridling, Pine Bluff  
District 5: Wayne G. Elliott, El Dorado  
Robert Nunnally, Camden  
District 6: James D. Armstrong, Ashdown  
John A. Gillean, Texarkana  
District 7: Robert McCrary, Hot Springs  
Thomas H. Hollis, Hot Springs  
District 8: Harold Purdy, Little Rock  
Charles Logan, Little Rock  
Paul Cornell, Little Rock  
David L. Barclay, Little Rock  
R. Jerry Mann, Little Rock  
William N. Jones, Little Rock  
Joseph M. Beck II, Little Rock  
J. Mayne Parker, Little Rock  
District 9: Robert H. Langston, Harrison  
David L. Rogers, Fayetteville  
Janet Titus, Winslow

*Ex-officio members shall have the power of voting on all subjects except the election of officers.*



Delegates for 1994 (as submitted by county)

County	Delegate	Alternate Delegate
Arkansas (1)		
Ashley (1)		
Baxter (2)		
Benton (4)		
Boone (1)		
Bradley (1)	Joe Wharton	Kerry Pennington
Carroll (1)		
Chicot (1)		
Clark (1)	Noland Hagood	
Cleburne (1)	G. Lee Vaughan	Michael Barnett
Columbia (1)	John Alexander, Jr.	
Conway (1)		
Craighead/Poinsett (7)		
Crawford (1)		
Crittenden (1)		
Cross (1)		
Dallas (1)		
Desha (1)		
Drew (1)		
Faulkner (2)	Randal Bowlin Ben Dodge	John Smith Phillip Stone
Franklin (1)		
Garland (6)		
Grant (1)	Jack Irvin	Clyde Paulk
Greene/Clay (1)		
Hempstead (1)		
Hot Spring (1)	Absalom Tilley	Larry Brashears
Howard/Pike (1)		
Independence (2)	William Waldrip J. R. Baker	Terry Sutterfield Jeff Angel
Jackson (1)	M. A. Chauhan	
Jefferson (4)		
Johnson (1)	Richard McKelvey	Donald Pennington
Lafayette (1)	Sanford Hutson	
Lawrence (1)		
Lee (1)		
Little River (1)	Joe Shelton	James Armstrong
Logan (1)	John R. Williams	
Lonoke (1)	Les Anderson	Garland Thorn
Miller (3)	Stanley Collins Joseph Robbins Herbert Wren	F. E. Joyce
Mississippi (1)	Joe V. Jones	Richard Hester
Monroe (1)		
Nevada (1)		
Ouachita (1)	William Dedman	Larry Braden
Phillips (1)	P. Vasudevan	R. Miller
Polk (1)	Thomas Tinnesz	David Fried
Pope (3)		
Pulaski (37)	D. B. Allen Raymond Biondo Amail Chudy Bob E. Cogburn Michael Cope David Coussens Phillip Deer Kurt Dilday Marlon Doucet	James Adamson John Brizzolara Roger Clark Byron Curtner Claudia Davis Gilbert Dean Sidney Eudy Eric Fraser Cynthia Frazier

Jim English	David Gilliam
Charles P. Fitzgerald	James Hagler
A. T. Gillespie	Thomas Hart
Edwin Hankins, III	Andrew Henry
Fred O. Henker	Tim Hodges
C. Reid Henry	Jerry Holton
Stephen Hodges	Harold Hutson
Tom Jansen	Gail Jones
Anthony D. Johnson	John Jones
Carl L. Johnson	Dean Kumpuris
David King	Joan Kyle
Marvin Leibovich	Stephen Magie
Judy McDonald	Jim Morse
Fred G. Nagel	David Mumme
George A. Norton	Walter O'Neal
Debra Owings	Richard Peek
Carl J. Raque	Michael Roberson
John F. Redman	Ian Santoro
Ashley S. Ross	
Ted Saer	
Bruce E. Schratz	
Frank M. Sipes	
William L. Steele	
Dyabe Velez	
Samuel Welch	
Steve Williamson	
John L. Wilson	
Paul W. Zelnick	
Paul Anderson	William Holmes
Jimmie Atkins	David Hunton
Mike Berumen	Steve Nelson
Randy Ennen	Jerry Stewart
R. Cole Goodman	Eric Taft
John Lang	
Jack Magness	
William Schemel	
Eugene Still	
John Swicegood	
John Wells	
Griffin Arnold	George Jackson
John A. Hall	
Curtis Hedberg	William Nowlin
Anthony Hui	
William McGowan	
Robert Pang	
Danny Proffitt	
David Rogers	
Janet Titus	
James Maupin	Gene Ring

*Ex-officio members shall have the power of voting on all subjects except the election of officers.*

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## First Meeting, House of Delegates

5:00 p.m., Thursday, April 7

John Crenshaw, M.D., Speaker

Brenda Powell, M.D., Vice Speaker

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1. Call to order
2. Presentation of the Colors
3. Welcome to Little Rock
4. Introduction of guests:
  - Mrs. Darlene Young, Secretary  
American Medical Association Alliance
  - Mrs. Joan Daus, President-elect  
Southern Medical Association Auxiliary
  - Mrs. Arleta Power, President  
Arkansas Medical Society Alliance, Little Rock
  - Mrs. MaryAnne Stallings, President-elect  
Arkansas Medical Society Alliance, Jonesboro
5. Address by Donald T. Lewers, M.D.
  - American Medical Association Board of Trustees  
Easton, Maryland
6. Adoption of minutes of the 117th Annual Session as published in the June 1993 issue of *The Journal of the Arkansas Medical Society*.
7. Memorials
8. Presentations
9. Old Business
10. New Business
  - All reports, resolutions, and other items of business received by the headquarters office 20 days prior to the meeting shall be included in the agenda. Any items of business received after March 18, must have two-thirds consent of attending delegates before introduction. All items will be referred to reference committees.
11. Announcement of vacancies on State Boards:
  - Arkansas State Board of Health (Second and Fourth Congressional Districts and Member at Large)
  - Arkansas State Medical Board (Fifth Congressional District)
12. Address by Michael F. Staley
13. Recess until Saturday

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## Final Meeting, House of Delegates

10:30 a.m., Saturday, April 9

John Crenshaw, M.D., Speaker

Brenda Powell, M.D., Vice Speaker

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1. Call to order
2. Election of officers. Nominations as submitted by the Nominating Committee:
  - President-elect:**  
James Armstrong, M.D., Ashdown
  - Vice President:**  
Scott Dinehart, M.D., Little Rock
  - Treasurer:**  
Lloyd G. Langston, M.D., Pine Bluff
  - Secretary:**  
Charles H. Rodgers, M.D., Little Rock
  - Speaker of the House:**  
John Crenshaw, M.D., Pine Bluff
  - Vice Speaker of the House:**  
Brenda Powell, M.D., Little Rock
  - Councilors:**
    - District #1:  
Dwight Williams, M.D., Paragould
    - District #2:  
Michael N. Moody, M.D., Salem
    - District #3:  
Parthasarathy Vasudevan, M.D., Helena
    - District #4:  
Paul A. Wallick, Monticello
    - District #5:  
Robert H. Nunnally, M.D., Camden
    - District #6:  
George Finley, M.D., Texarkana
    - District #7:  
Robert F. McCrary Jr., M.D., Hot Springs
    - District #8:  
David L. Barclay, M.D., Little Rock  
R. Jerry Mann, M.D., Little Rock  
John L. Wilson, M.D., Little Rock
    - District #9:  
Robert H. Langston, M.D., Harrison  
Janet Titus, M.D., Winslow
    - District #10:  
Morton C. Wilson, M.D., Fort Smith  
Gerald A. Stolz, M.D., Russellville
- Delegates to the American Medical Association (Term 1/1/95 - 12/31/96):**
  - John P. Burge, M.D., Lake Village
  - William N. Jones, M.D., Little Rock



**Alternate Delegates to the American Medical Association (Term 1/1/95 - 12/31/96):**

David L. Rogers, M.D., Fayetteville  
John M. Hestir, M.D., DeWitt

3. Address by 1993-94 President of the Arkansas Medical Society, Glen F. Baker, M.D.
4. Reports of Reference Committees:  
Committee #1  
Committee #2
5. Supplemental report of the Council:  
Charles Logan, M.D., Chairman  
(Report covers meetings of the Council held during the annual session.)
6. New Business:  
Announcement of nominees for the Arkansas State Board of Health and the Arkansas State Medical Board  
Other new business

## State Board Vacancies

### Arkansas State Board of Health

A vacancy will occur December 31, 1994, in the Second and Fourth Congressional Districts and Member at Large of the Arkansas State Board of Health. Members from the counties in the district are urged to meet immediately following the adjournment of the House of Delegates on Thursday to vote for nominees. The term of office is four years. Nominations should be reported to Kay Waldo, Director of Administrative Services, immediately following the caucuses (three nominations are required).

**SECOND CONGRESSIONAL DISTRICT:** Kenneth R. Meacham, M.D., of Searcy is currently serving the term which will expire in December, 1994. Dr. Meacham is eligible to succeed himself.

Counties in the Second Congressional District include Cleburne, Fulton, Independence, Izard, Jackson, Lawrence, Monroe, Prairie, Randolph, Sharp, Stone, White and Woodruff.

**FOURTH CONGRESSIONAL DISTRICT:** Raymond N. Bowman, M.D., of El Dorado is currently serving the term which will expire in December, 1994. Dr. Bowman is eligible to succeed himself.

Counties in the Fourth Congressional District include Ashley, Bradley, Calhoun, Clark, Columbia, Hempstead, Howard, Little River, Lafayette, Miller, Montgomery, Nevada, Ouachita, Pike, Polk, Sevier and Union.

**MEMBER AT LARGE:** Michael Moody is currently serving the term which will expire in December, 1994. He is eligible to succeed himself.

Member at Large position is selected by the Nominating Committee during Annual Session.

### Arkansas State Medical Board

A vacancy will occur December 31, 1994, in the Fifth Congressional District position of the Arkansas State Medical Board. The term of office will be for eight years. Members from the counties in the district are urged to meet immediately following the adjournment of the House of Delegates on Thursday to vote for nominees. Nominations should be reported to the Society personnel immediately following the caucuses (three nomination are required).

**FIFTH CONGRESSIONAL DISTRICT:** Warren Douglas, M.D., of Little Rock, is currently serving the term which will expire, December, 1994. Dr. Douglas is eligible to succeed himself.

Counties in the Fifth Congressional District include Conway, Faulkner, Perry, Pope, Pulaski and Yell.

## Meetings of the Council

The Council will meet at the following times:

Thursday, April 7	2:00 p.m.
Friday, April 8	7:30 a.m.
Saturday, April 9	7:30 a.m.

## Reference Committees

Reference Committees are appointed by the Speaker of the House of Delegates to consider the various reports and resolutions. Reports published in this issue of *The Journal*, as well as any reports and resolutions presented at the first meeting of the House on April 7, will be referred by the Speaker to the reference committees. The committees will hold open hearings at 9:30 a.m. on Friday, April 8. After the hearings, the reference committees will hold executive sessions for the purpose of preparing recommendations and reports for the House of Delegates. Reports of the Reference Committees will be acted upon by the House of Delegates at the Saturday session.

### Reference Committee Orientation

There will be a meeting of all reference committee members on Friday, April 8 at 9:00 a.m. in the LaSalle Room of the Excelsior Hotel. The meeting will be to familiarize the reference committees with the rules, procedures and writing of the reference committee reports.

# *...a promise to defend...*

**HERE ARE THE FACTS:** Over 25% of America's Physicians were embroiled in a malpractice issue in the last 12 months. More than 80% of those malpractice allegations will be closed without an award for damages. Your professional reputation and your personal assets are on the line when your professional liability carrier is not both financially sound *and* experienced in the law and the judicial system.

**WHEN THE ISSUES ARE LEGAL, NOT MEDICAL--** when the allegations are frivolous, or highly emotional-- you need a company and legal representation that understands the problem and has the experience to resolve the issue. The Medical Protective Company has specialized in defending doctors since 1899. Our legal and claims management experience is unmatched by any other insurer in the U.S.

**FOR MORE INFORMATION** on how we can protect your professional reputation and your personal assets, call your local Medical Protective General Agent at 1-800-344-1899.

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**A+ (Superior) A.M. Best**

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# Reference Committee Agendas

**Reference Committee #1**  
**LaSalle Room/Excelsior Hotel**  
**9:30 a.m., Friday, April 8, 1994**

**Roger Cagle, M.D., Paragould**  
**Reference Committee Chairman**

## Agenda

1. Annual Session Committee, R. Jerry Mann, M.D., Chairman
2. Arkansas Health Care Access Foundation, Harold Hedges, M.D., Chairman
3. Arkansas State Medical Board, Peggy Pryor Cryer, Executive Secretary
4. Ouachita County Medical Society, Robert H. Nunnally, M.D., Secretary/Treasurer
5. Physicians' Health Committee, Joe Martindale, M.D., Director
6. Pulaski County Medical Society, Fred Reddoch, Executive Director
7. Report of the Council, Charles W. Logan, M.D., Chairman
8. Task Force on AIDS, Joseph M. Beck II, M.D., Chairman
9. Tenth Councilor District, Morton C. Wilson, M.D., Gerald Stolz, M.D., Paul Wills, M.D., Councilors
10. Young Physicians' Committee, Anna Ridling, M.D., Chairman

**Reference Committee #2**  
**LaHarpe Room/Excelsior Hotel**  
**9:30 a.m., Friday, April 8, 1994**

**Joe Jones, M.D., Blytheville**  
**Reference Committee Chairman**

## Agenda

1. Budget Committee, Paul Wallick, M.D., Chairman
2. CME Accreditation Committee, Walter O'Neal, M.D., Chairman
3. Governmental Affairs Council, Charles H. Rodgers, M.D., Chairman
4. Managed Care Committee, Glen F. Baker, M.D., Chairman
5. Medical Education Foundation for Arkansas, Martin Eisle, M.D., President
6. Medical Services Review Committee, John Crenshaw, M.D., Chairman
7. Nominating Committee, Michael Moody, M.D., Chairman
8. Pension Plan Trustees, William Rutledge, M.D., Chairman
9. Report of the Executive Vice President, Ken LaMastus, CAE
10. Report of the Arkansas Department of Health to the Arkansas Medical Society, Tom Butler, Deputy Director of Administration

## Memorials

Members of the Arkansas Medical Society and Alliance who have died during this past year will be remembered during the opening House of Delegates beginning at 5:00 p.m., Thursday, April 7 in Salon B of the Excelsior Hotel. Members to be honored are:

### *Society Members*

Edward J. Bass, El Dorado	William O. Green, Maumelle	William T. Raney, Cave City
Lee F. Beamer, Hot Springs Village	Thomas G. Johnston, Little Rock	Earnest L. Saunders, Jonesboro
Sam F. Brown, Texarkana	Henry V. Kirby, Harrison	Vernon L. Toombs, Gurdon
William W. Christeson, Little Rock	Oscar Kozberg, Little Rock	Joe Verser, Harrisburg
Hugh R. Edwards, Searcy	Harold D. Langston, Little Rock	James W. Webb, Jonesboro
Robert A. Fisher, Little Rock	Ruth E. Lesh, Fayetteville	
Jean Gladden, Harrison	Milton Lubin, West Memphis	

### *Alliance Members and Spouses*

Mrs. Charles A. Archer (Mary), Benton	Mrs. Arch A. Little (Marquerite), Texarkana
Mrs. Sylvan Bartlett (Barbara), Midland, TX	Mrs. F. LaMar McMillin (Claudia), Little Rock
Mrs. Robert A. Calcote (Kay), Lonoke	Mrs. Chalmers S. Pool (Mathilde), Little Rock
Mrs. John C. Gilliland (Carole), Fort Smith	Mrs. William Salter (Johanna), Texarkana, TX



# IT'S TIME YOUR PRACTICE HAD A CHECKUP...

If you were disabled:

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Would your practice's rent or mortgage be paid?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your employees' salaries be paid?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your employees receive the benefits you promised them?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would installments or lease payments on office equipment be paid? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your professional liability insurance premiums be paid?     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your property and casualty insurance premiums be paid?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your practice's taxes be paid?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your practice's utility bills be paid?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would professional or trade dues be paid?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your accounting, billing, and collection fees be paid?      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Would your mailing and subscription costs be paid?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you checked "No" to any of these questions, your practice failed the checkup.  
But your practice doesn't have to suffer when you become disabled.

**Keep your practice healthy with a Business Overhead Expense policy from Provident.**

Arkansas Medical Society members are eligible for a 15% discount, a non-smoker discount, and volume discounts.

For more information, contact your local Provident disability branch office.



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## Annual Session Committee

### Jerry Mann, M.D., Chairman

The Arkansas Medical Society was "On The Right Track" in Hot Springs April 15-17, 1993, at the Arlington Hotel. The meeting opened with "Sustaining Our Healing Spirit" presented by Carl Hammerschlag, M.D., a practicing psychiatrist and faculty member at the University of Arizona Medical School. Other speakers and topics include:

#### "CLIA 88: The Law, The Regulations, and Impact on Physicians"

Paul Bachner, M.D., Chairman of the Department of Pathology and Laboratory Medicine at the United Hospital Medical Center in Port Chester, New York

Shuffield Luncheon/Lecture Speaker  
Ed Goaes, President and CEO of the Tarrance Group, a respected and successful Republican survey research and strategy team in American politics

#### "Federal Legislative Activities in Regard to Health Care Reform"

U. S. Congressman Jay Dickey

#### "Reform of the U.S. Health Care System"

Ed Haislmaier, Senior Policy Analyst for Health Care Issues at the Heritage Foundation

#### "Universal Health Care - The Minnesota Plan"

Paul Anders Ogren, a former state representative

In addition to the educational sessions, exhibitors were on hand to show their products and services on Thursday and Friday. Physicians and their spouses also attended the Arkansas Blue Cross Blue Shield reception on Thursday evening and a party on Friday night featuring the KSSN Bandits.

The convention came to an end on Saturday evening with the Inaugural Banquet and a special guest double-talk artist Eloise Hope and the late Art Porter entertained guests at the President's Reception.

## Arkansas Health Care Access Foundation, Inc.

### Harold Hedges, M.D., Chairman

For the past four years, the Arkansas Health Care Access Foundation, Inc., (AHCAF) has been dedicated to helping the medically indigent in Arkansas gain access to free and reduced cost medical care. Accessible health care is crucial to maintaining an adequate quality of life in the state. You and your colleagues have played an integral role in AHCAF'S pursuit of this goal.

The Foundation boasts over 970 physician volunteers. Through its network of over 1,700 health professionals such as physicians, dentists, pharmacists, pharmaceutical manufacturers, hospitals, home health agencies, the State Department of Health and the State Department of Human Services, it has provided in excess of \$615,000.00 in medical care, to over 27,000 needy Arkansans. Rarely, have so many different types of health care professionals united in one state wide endeavor!

The board continues in its aim to provide health care to Arkansas' medically indigent, by looking at additional ways of helping them to access that care. This past year, improvement has been made in the application process, by allowing the Department of Health units to act as an added point of entry into the referral system. Now, needy Arkansans may apply for the program from anywhere in the state, through local county Department of Human Services offices and local Public Health units.

Informing eligible needy Arkansans about this service, is an ongoing effort by the AHCAF. Its Board of Directors continues to pursue new and innovative ways of accomplishing this. Presently, AHCAF is working with KATV, Channel 7, in planning a state wide media campaign which will include television and radio broadcasts, and possible billboard displays. This will be accomplished through the generosity of Dale Nicholson, who has recently joined our board.

Recruitment of additional volunteer physicians is always a high priority for the Foundation. Approached last year by Poplar House Clinic in Rogers, Arkansas, AHCAF was asked to assist their free clinic patients with obtaining help with their prescriptions. By listing their volunteer physicians with this Foundation and getting their needy patients approved on this program, we have been able to assist the clinic in meeting the prescription needs of some of their patients. We hope that other local free clinics will show interest in adopting this method of providing additional medical assistance to their indigent patients.

The staff and board have been active this past year by participating as spokespersons on radio talk shows, workshops and inservices to help promote the Foundation's work. Staff and board members are always available for inservice to your county medical society meetings and would welcome the opportunity to share information about indigent health care access in Arkansas.

Support from all sectors of the health care community is one of the keys to maintaining a successful program. Our family of health care professionals continues its commitment to serve those Arkansans who are poor and medically uninsured. Thank you for making AHCAF the type of program that has made a difference in many lives.

If you think you might be interested in donating a few minutes in your office to indigent care, but would like more information about the program, please contact one of the physician board members listed below.

Harold Hedges, M.D.	
Little Rock	664-4810
John Burge, M.D.	
Lake Village	265-5343
Simmie Armstrong, M.D.	
Pine Bluff	535-6461
Lawrence Braden, M.D.	
Camden	836-5013
Gilbert Buchanan, M.D.	
Little Rock	664-4117
John Hestir, M.D.	
DeWitt	946-3637
Judy McDonald, M.D.	
Little Rock	223-2929
R. Wendell Ross, M.D.	
Van Buren	474-1100
Joe Stallings, M.D.	
Jonesboro	932-8121
Joe Colclasure, M.D.	
Little Rock	227-5050
Ray Jouett, M.D.	661-9337
Little Rock	

## Budget Committee

### Paul Wallick, M.D., 1993 Chairman

The Budget Committee submitted the following budget for 1994. The complete budget, as presented to the Council, is available to members upon request.

### Arkansas Medical Society

Income	Amount Budgeted
State Society Dues 1994	\$650,000.00
Journal Advertising	89,000.00
Booth Income 1994	40,000.00

Annual Session	38,000.00
AMA Reimbursement	14,000.00
Miscellaneous & Rosters	13,500.00
Interest Income	28,000.00
Specialty Desk	2,728.00
Continuing Medical Education	1,000.00
Allocation of G.A. Department	5,000.00
Educational Programs	13,000.00

**Total** **\$894,228.00**

### Expenses

Salaries	\$265,632.00
Travel & Convention	40,000.00
President's Account	6,000.00
Taxes	22,500.00
Retirement	31,000.00
Stationery & Printing	15,000.00
Office Supplies & Expenses	23,000.00
Telephone	11,000.00
Rent	79,672.00
Postage	30,000.00
Insurance & Bonds	56,000.00
Auditing	6,775.00
Council & Executive Committee	4,800.00
Journal Expense	72,500.00
Dues & Subscriptions	3,500.00
Gifts & Contributions	2,500.00
Auxiliary	2,200.00
Legal Services (retainer)	27,426.00
Special Committee	2,700.00
Public Relations	3,000.00
Miscellaneous Expenses	5,000.00
Office Equipment & Furniture	8,000.00
Continuing Medical Education	1,000.00
Richmond Early Retirement	5,820.00
Contract Labor	2,500.00
Winter Meeting	2,200.00
AMS Resident & Student Section	5,500.00
Annual Session 1993	70,500.00
Educational Programs	9,000.00
Physicians Health Committee	10,000.00
MEFFA - Dues	11,000.00
Managed Care	0.00
DHS Lawsuit - Legal Expenses	0.00
DHS Lawsuit - Other Expenses	0.00

**Total** **\$835,725.00**



**"Take Me Out to the Ballgame"  
Party  
Friday, April 8, 1994  
118th Annual Session**



## Department of Governmental Affairs

Income	\$217,000.00
Expenses	
Salaries	\$96,892.00
Retirement	10,900.00
Taxes	7,000.00
Stationery & Printing	4,500.00
Office Sup, Telephone, Misc Exp	6,500.00
Equipment & Furniture	1,000.00
Auto, Travel & Meeting	40,000.00
Legal Retainer	18,300.00
Postage	7,500.00
Insurance & Bonds	11,000.00
Office Allocation To AMS	5,000.00
Audit	1,250.00
Total	\$209,842.00

### **Continuing Medical Education Accreditation Committee Walter O'Neal, M.D.**

The Arkansas Medical Society is the official accrediting body for organizations that provide or sponsor CME for physicians within the state of Arkansas. The accreditation activities are carried out by the CME Accreditation Committee which currently consists of Drs. Charles Mabry, Leslie Anderson, Gerald Stolz, Morton Wilson, Steve Strode and myself. Kay Waldo and David Wroten of the AMS provide the administrative support necessary to fulfill our mission.

During the past year the committee has reviewed eight organizations, all hospitals, for reaccreditation. The results of those reviews are as follows:

#### **Full Accreditation:**

- for 4 years - 1 hospital
- for 3 years - 2 hospitals
- for 2 years - 2 hospitals

#### **Provisional (reserved for new applicants or currently accredited sponsors with new programs)**

- for 1 year - 1 hospital

#### **Probationary Accreditation**

- for 2 years - 1 hospital

#### **Other**

- 1 hospital voluntarily withdrew

In August of 1993 our committee was reviewed by the Committee for Review and Recognition (CRR) of the Accreditation Council for Continuing Medical Education (ACCME). The ACCME is the national organi-

zation that officially recognizes AMS as the accrediting body for Arkansas. The AMS was awarded Continued Recognition for a period of two years.

Our committee will be requesting approval from the AMS Council to increase the fees charged to organizations seeking accreditation. The request is significant in that for the first time we will be asking accredited organizations to cover most of the real costs associated with the accreditation process. In the past the AMS has heavily subsidized the program. We feel that the hospitals that benefit from the accreditation program should begin to support the actual costs to keep it going.

The current fees charged are shown below for comparison to the new fees being proposed:

	<u>Current</u>	<u>Proposed</u>
Initial Survey	\$300	\$1,500
Reaccreditation Survey	300	900
Annual Dues	100	450
Interim Report	-0-	200

The current fees for initial and reaccreditation surveys do not include additional costs for surveyor expenses which are paid directly by the hospitals. However, the proposed fees are all inclusive and will not require additional expenditures by the hospital.

While these fees may seem high, they are still quite reasonable when compared to the fees charged to be accredited directly by the ACCME. For example, the initial survey fee charged by ACCME is \$2,600 and reaccreditation surveys are \$1,750.

This concludes the report of the CME Accreditation Committee. My sincerest thanks to the committee members and staff for the hard work that they all contribute to this process.

### **Governmental Affairs Council Charles Rodgers, M.D., Chairman**

Last year's report of the Governmental Affairs Council outlined the victories we enjoyed in '92-'93. A defeat of a 1% gross receipts tax on physician's medical practice; successful negotiation of a reasonable worker's compensation fee schedule; the winning of a lawsuit against DHS, prohibiting a reduction in Medicaid reimbursement; defeating an AARP proposal requiring physicians to see ALL Medicare patients; and several other significant wins. But, the report came with a warning that the future holds even greater threats...

Reactions to health care reform proposals by the public, insurance carriers, and physicians are pointing toward usurped medical judgements, non-physician practice of medicine, unrealistic and inflexible fee caps, and perplexed and betrayed patients. Medicine is no longer patient driven, but rather cost driven with more government control.

THE URGENCY OF IMMEDIATE PHYSICIAN INVOLVEMENT CANNOT BE UNDERESTIMATED. Physicians and their patients are at a crossroads, and whatever happens in the Arkansas General Assembly and the Congress in the next few months may determine for subsequent generations the quality and availability of health care.

The competency of our AMS lobbyist and the few politically interested members have served us well over the years, but the threat of government intervention has become more extreme and more imminent. Physicians can no longer stay out of the fray, assume that reason will win the day and that their practices will remain unaffected.

The Governmental Affairs Council will continue to monitor legislative proposals from both the state and federal governments. We will also monitor the activities of the Governor's Health Care Task Force and other health related committees. But, IT IS IMPERATIVE, that you read the AMS newsletter and legislative bulletins, and you must respond when we have a call to action.

We are all busy people, but one phone call a week, one letter a week, or one visit to the Capitol doesn't take that long. Now more than ever before your INDIVIDUAL actions may make the difference between victory and defeat.

### **Managed Care Committee Glen F. Baker, M.D., Chairman**

During Governor Clinton's campaign for President, one of his major issues was health system reform and national health insurance. During his first year as President we began seeing health system reform throughout Arkansas. Emphasis was placed on health system reform by a variety of organizations including insurance companies and hospitals or a combination of both.

One of my goals as the 1993/1994 president of the Arkansas Medical Society was to attempt to address the physicians' role in health care reform activities. During my inaugural speech I indicated that a special committee would be appointed to evaluate what the Arkansas Medical Society's role should be in health system reform and the managed care environment. A committee consisting of the members of the AMS Executive Committee and Drs. Mike Moody and James Weber was appointed. Upon the recommendation of this committee the AMS Council authorized a study to see if it was feasible for the AMS to set up some type of managed care program. The results of this feasibility study was referred to the House of Delegates in November 1993 and a decision to proceed with developing a managed care organization controlled by physicians of the AMS was made. It was felt that this organization could provide cost effective, quality medical care and that physicians of this state could better de-

cide what constitutes quality and needed services more than insurance companies or hospitals.

The Arkansas Medical Society has organized a wholly owned subsidiary, AMS Management Company, which is developing a network of local managed care organizations (MCO's) across the state. These local networks will be competitive in cost and superior in quality and access to care. The AMS Management Company will work with local physicians to establish their own MCO's. Through these MCO's physicians and employers can develop a plan and product best suited to the specific needs of their community. By establishing local MCO's throughout the state AMS will be in a position to offer large and small employers and insurers access to a statewide network of physicians. The AMS Management Company will provide all staff and services necessary to operate each local MCO.

The AMS Management Company will negotiate hospitals and ancillary providers for contracts with the local MCO's. It will also provide marketing, administrative services, product development, coordination of utilization review, and a fee schedule.

The AMS Management Company will provide all professional and legal services and the local MCO will proceed under the guidance of local physician/employer boards. Contracts with employers will be approved by the local MCO board of directors. In the case of statewide employers the MCO where the headquarters is located will approve the contract for the entire state.

The AMS committed to the program after receiving pledges of \$300 from more than 1,000 AMS members statewide, representing a variety of specialists. The AMS invested the first \$100,000 for start-up costs. Ongoing financing will come from the administrative fees paid by the participating subscribers to the management company.

Janell Mason has been named the chief operating officer of the AMS Management Company. Ms. Mason formerly managed the Arkansas Preferred Provider Organization in Pine Bluff and has 14 years experience doing contract work with physicians. Staff is being hired at this time and the office should be in full operation by the last of February.

### **Medical Education Foundation for Arkansas (MEFFA) W. Martin Eisele, M.D., President**

The members of the Board of Directors of the Medical Education Foundation for Arkansas are W. Martin Eisele, M.D., President; James F. Kyser, M.D.; William Bishop, M.D.; and Gerald Stolz, M.D. Ex-officio members are the Arkansas Medical Society president, president-elect and immediate past president, and the dean at UAMS.



The foundation is supported by \$5 from each full dues paying member of the Arkansas Medical Society; those paying partial dues make a proportionate contribution. The primary purpose of MEFFA is to provide support and benefit to medical students at UAMS. The funds provided approximately ten out-of-state guest lecturers for the medical school.

Although the year-end 1993 audit has not been completed we anticipate that MEFFA income has exceeded expenditures. An independent CPA firm audits MEFFA each year and copies are provided to the Council of the Arkansas Medical Society.

The MEFFA Board encourages physicians and their families to make tax deductible contributions.

**Medical Services Review Committee**  
**John Crenshaw, M.D., Chairman**

The Medical Services Review Committee had a turbulent year. At the request of the Council, we suspended meetings for several months and revised our policies and procedures. The current policies and procedures have been approved by the AMS Executive Committee and will be discussed at the next Council meeting.

The MSRC was formed to assist insurance companies in general, but Blue Cross has been the only company that has utilized this opportunity. Dr. James Adamson has been named the medical director for Arkansas Blue Cross Blue Shield and Dr. Lewis Crow is the assistant medical director.

The reorganization of the MSRC should result in a broader function to serve the patients in the state of Arkansas by providing proper review policies by practicing physicians. The changing federal regulations and health delivery systems have resulted in this re-evaluation with minor modifications of our procedures.

**Nominating Committee**  
**Michael Moody, M.D., Chairman**

The Nominating Committee met on Sunday, September 26, 1993, at the Holiday Inn West in Little Rock. The committee met again by conference call on Wednesday, December 15, 1993. We wish to present to the Society the following nominees:

- President-elect:**  
James Armstrong, M.D., Ashdown  
**Vice President:**  
Scott Dinehart, M.D., Little Rock  
**Treasurer:**  
Lloyd Langston, M.D., Pine Bluff  
**Secretary:**  
Charles Rodgers, M.D., Little Rock



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John Crenshaw, M.D., Pine Bluff

**Vice Speaker of the House:**

Brenda Powell, M.D., Hot Springs

**Delegates to the AMA:**

John Burge, M.D., Lake Village (1/1/95 - 12/31/96)

William Jones, M.D., Little Rock (1/1/95 - 12/31/96)

**Alternate Delegate to the AMA:**

David Rogers, M.D., Fayetteville (1/1/95 - 12/31/96)

John Hestir, M.D., DeWitt (1/1/95 - 12/31/96)

**Councilors:**

- District 1: Dwight Williams, M.D., Paragould  
District 2: Michael Moody, M.D., Salem  
District 3: Parthasarathy Vasudevan, M.D., Helena  
District 4: Paul Wallick, M.D., Monticello  
District 5: Robert Nunnally, M.D., Camden  
District 6: George Finley, M.D., Texarkana  
District 7: Robert F. McCrary, Jr., M.D., Hot Springs  
District 8: David Barclay, M.D., Little Rock  
Jerry Mann, M.D., Little Rock  
John L. Wilson, M.D., Little Rock  
District 9: Robert Langston, M.D., Harrison  
Janet Titus, M.D., Winslow  
District 10: Morton Wilson, M.D., Fort Smith  
Gerald Stolz, M.D., Russellville

## **Ouachita County Medical Society**

### **Robert H. Nunnally, Secretary/Treasurer**

The Ouachita County Medical Society had a total of six meetings during 1993. Guest speakers were invited for five of those meetings.

Early in the year discussions among the members of the Ouachita County Medical Society were focused upon the UAMS AHEC system's entry into competitive private practice via the Arkansas State Employee's Insurance Plan. The University of Arkansas Medical Center's extensive television advertising program was also noted.

As the year progressed the proliferation of HMO's and PPO's in the state became apparent as the various institutions and insurers maneuvered to improve their positions prior to the development of the Clinton Health Plan. On July 27, 1993, Dr. Glen Baker, David Wroten, and Mike Mitchell from the Arkansas Medical Society spoke to our society about these developments.

The members of the Ouachita County Medical Society were saddened by the loss of our president, Dr. Cal R. Sanders, through disability retirement in October 1993. We join in the hope that Cal's health will improve and that he will be able to return to active practice.

### **TAKE THE FIRST STEP TO RECOVERY**

The Arkansas Medical Society Physicians' Health Committee is interested in the well being of Arkansas physicians. Through effective intervention, treatment referral and monitoring of health conditions, the Physicians' Health Committee's services enable physicians to continue to deliver safe and effective patient care.

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The Society was pleased to have one of its members, Dr. Bill Dedman, become president-elect of the Arkansas Academy of Family Physicians.

The final meeting of 1993 was held in the conference room of the Ouachita County Hospital on December 28. Officers for 1994 are Dr. Bill Dedman, President; Dr. David Mosley, Vice President; Robert H. Nunnally, Secretary/Treasurer; Dr. Bill Dedman, Delegate to the AMS; and Dr. Larry Braden, Alternate Delegate to the AMS.

## **Pension Plan Trustees**

### **William Rutledge, M.D., 1993 Chairman**

The Arkansas Medical Society Pension Plan Board of Trustees has continued to receive reports on the plan. In 1993, the annualized rate of return was 10.03%. There has been no changes in the policies of the plan as to investments or benefits.

The plan continues to be managed by Worthen Trust Company. Worthen Trust Company provides reports on an annual basis as to the value of their holdings and quarterly reports on investment earnings. A copy of this information is provided to the Pension Plan Trustees and Arkansas Medical Society employees.

## **Physicians' Health Committee**

### **Joe L. Martindale, M.D., Director**

Members of the Physicians' Health Committee are James A. Arnold, Fayetteville, John R. Baker, Batesville, Carl H. Bell, Jr., Pine Bluff, Gary Harper, Little Rock, Forrest Miller, Little Rock, Robert L. Ross, Pine Bluff, Patrick J. Savage, Jonesboro, and Jerry Stringfellow, Texarkana. The Physicians' Health Committee has intervened with approximately twelve physicians in 1993.

Funding was received from the following organizations during 1993: Arkansas Medical Society - \$10,000; Arkansas State Medical Board - \$10,000; State Volunteer Mutual Insurance Company - \$5,000; and St. Paul Fire and Marine Insurance Company - \$885.45.

<b>Income</b>	<b>\$45,000.00</b>
<b>Expenses</b>	
Contract Medical Director	\$35,000.00
Office Supplies & Postage	1,000.00
Telephone & Answering Service	600.00
Travel - Medical Director	2,000.00
Miscellaneous Expenses	550.00
<b>Total</b>	<b>\$39,150.00</b>



## **Pulaski County Medical Society Fred Reddoch, Executive Director**

Under the leadership of our president, Dr. D. B. Allen, the Society had a good year in 1993. Highlights of the year include the following:

- financial support of Med-Camps of Arkansas
- a scholarship was presented to a University of Arkansas medical student
- administrative support of the Senior Physicians of Arkansas
- 6% growth in membership
- continued management of the Pulaski County Medical Exchange
- a meeting devoted to recent changes in the state Medicaid program
- negotiations with Discover Card for a discounted rate for members

The Society anticipates another year of growth and activity under our 1994 president, Dr. Joseph M. Beck.

## **Report of the Council**

**Charles Logan, M.D., Chairman**

### **AMS Council:**

The Council met on Sunday, June 27, 1993, at the Little Rock Hilton Inn and the following business was received and transacted:

1. Approved the minutes of the April 15-17, 1993 Council meetings.
2. Approved the minutes of the May 13, 1993 Executive Committee meeting.
3. Approved the minutes of the May 26, 1993 Executive Committee meeting.
4. Dr. Andrew Kumpuris gave a presentation on the Clinton Administration Health Care Reform Package to be released later this year. Dr. Kumpuris explained why there is a need for health care reform and some of the changes physicians can expect.
5. The Council voted by acclamation to elect Dr. Gary Bevill as Vice President of the Arkansas Medical Society.
6. Mr. Lynn Zeno reported on the meeting with Hillary Clinton and President Bill Clinton which was attended by physicians from the Fourth Congressional District.
7. Dr. Payton Kolb reported on the AMA meeting held in Chicago, June 13-17.

8. Dr. Morton Wilson gave an update on the Arkansas Foundation for Medical Care. Dr. Wilson informed the Council of the medical director position available and announced that his position as assistant medical director had been eliminated. The Council recognized Dr. Wilson for his work on the PRO.
9. Chairman Logan read a report prepared by Dr. Joseph Beck on the State Medical Board's regulations pertaining to HIV and HBV positive physicians. Upon motion the Council voted to submit a resolution to the State Board of Health asking that they adopt a single set of guidelines for all health care providers. The Council voted for the AMS to publish the regulations and asked physician members of the Society who are concerned to contact State Medical Board members in their area to ask them to reconsider the regulations.
10. Mr. Mike Mitchell discussed the Notice of Appeal filed by the Arkansas Department of Human Services and the request for attorney's fees in the amount of \$136,044 filed on behalf of the Arkansas Medical Society.

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11. The Membership and Budget Reports were presented for information. Mr. Ken LaMastus noted that membership was on the rise with many requests for applications and information from non-members currently being received by the Arkansas Medical Society.
12. Upon motion the following physicians were approved for emeritus membership: Terry Swaim (Benton County), James Knapp (Benton County), and William Lockhart (Sebastian County). Dr. Larry D. Wright of Benton County was approved for affiliate membership.
13. Dr. William Jones announced the AMA dues increase of \$20.00 to \$420.00.

The Council adjourned and reconvened in Executive Session. Minutes of Executive Sessions are available for review by any member at the Society office.

**The Council met on September 26, 1993, at the Little Rock Hilton Inn and the following business was received and transacted:**

1. Approved the minutes of the June 27, 1993 Council meeting.
2. Approved the minutes of the following Executive Committee meetings: June 27, 1993 and July 28, 1993 (with correction on the date of Dr. Logan's signature).
3. Dr. Terry Poling and Mr. James M. Van Milligen, Associate Director of the Medical Society of Sedgwick County, Kansas, gave a summary of their managed care program which is the second largest in Kansas and the largest managed care program outside the metropolitan area.
4. Dr. James Armstrong gave an update on the activities of the Arkansas Foundation for Medical Care. He announced the position of medical director had been filled by Dr. Kevin J. Kenny, a family practice physician from Pennsylvania with over thirty years experience. Dr. Armstrong thanked Dr. Morton Wilson for his work with the PRO.
5. The Council approved the nomination of Dr. Parthasarathy Vasudevan of Helena to fill the vacancy of councilor in the Third Councilor District.
6. David Wroten, Assistant Executive Vice President, and Mike Mitchell, AMS Legal Counsel, gave an update on the lawsuit against the Arkansas Department of Human Services.

David Wroten reported that DHS had submitted a proposal to Judge Wright to adopt the Medicare fee schedule. The AMS has filed a response as opposed to that. The Eighth Circuit Court of Appeals has upheld all of Judge Wright's earlier rulings. We have agreed to give DHS until November 1 to negotiate an acceptable plan. If they do not offer one, the judge is prepared to issue a ruling. Mike Mitchell praised David Wroten for his hard work on the lawsuit.

7. Arleta Power, President of the Arkansas Medical Society Alliance, gave an update on the Alliance's activities and asked the AMS officers and councilors to encourage their spouses to become active in the Alliance.
8. The membership and budget reports were submitted for information. David Wroten informed the Council there had been a 20% increase in membership in the last three years with 75-85% of licensed physicians in the state as members.
9. Dr. William Jones reported on the Council's request for the Arkansas Department of Health to submit one set of guidelines to the CDC for all medical providers regarding HIV and HBV infected health care workers. The Arkansas Department of Health did not act upon the request. The AIDS Advisory Committee voted to not support the Health Department in their plan. The committee is continuing its negotiations with the State Medical Board to be the advisory committee and serve as an impaired physicians committee.

The Council adjourned to reconvene in Executive Session. Minutes of Executive Sessions are available for review by any member at the Society office.

**The Council met on Sunday, November 7, 1993, at the Camelot Hotel in Little Rock and the following business was received and transacted:**

1. Approved the minutes of the September 26, 1993 Council meeting.
2. Approved the minutes of the October 27, 1993 Managed Care Committee meeting.
3. Two position papers, Utilization Review and Freedom of Choice, were presented for information.
4. The Membership Report for the period ending September 30, 1993 was presented for information.



5. Dr. William Jones gave an update on CHAR and the Dental Board's policy for HIV infected dental professionals.
6. Dr. James Kolb reported on the managed care meeting sponsored by the American Medical Association that he and other officers attended in October. Dr. Kolb also discussed eleven questions recently published by the AMA concerning health care reform and urged everyone to copy these and make them available for their patients. The AMS staff will be sending these to councilors.
7. Dr. Lloyd Langston discussed Senate Bill 868 entitled the "Firearm Victims Prevention Act" which, if passed, would generate new taxes to be designated exclusively for the treatment and rehabilitation of gunshot victims and would redirect funds from successful hunter education programs. Upon motion the Council approved a resolution to be presented to the AMA at its December meeting opposing Senate Bill 868.

The Council adjourned to reconvene in Executive Session. Minutes of Executive Sessions are available for review by any member at the Society office.

#### AMS Executive Committee:

The Executive Committee of the Council of the Arkansas Medical Society met on Thursday, May 13, 1993, at the Medical Society Office in Little Rock. The following business was received and transacted:

1. The Executive Committee approved a letter to be written to the Health Department in support of a smoking cessation program the Department of Health is seeking funds for. It was suggested that the letter be written after conversing with the health department concerning the medical society participating in the program.
2. The Executive Committee discussed the DHS lawsuit and what appeared to be noncompliance on the part of DHS.
3. Dr. Glen Baker, as president of the Society, presented his plan for working with physicians across the state in getting prepared for the various types of managed care programs. He discussed the meetings he recently attended in Helena and West Memphis and the concerns expressed by physicians in those areas about the need for more assistance in dealing with these organizations.
4. Dr. Baker discussed Act 591 of 1993, the Arkansas

Health Resources Commission legislation. It was Dr. Baker's opinion that a lot of the areas addressed in the act could be later on be used to formulate plans for national health insurance. He expressed concern that we have knowledgeable physicians serve on this committee.

5. The Committee discussed the possible need to appoint a new member to the Arkansas State Medical Board. A vacancy may occur because of the anticipated resignation of one its current members.
6. Dr. Baker discussed the Physicians' Health Committee and conversations he had with Dr. Joe Martindale concerning adequate funding for the program. A report from Dr. Martindale was reviewed. The Committee has intervened with over 100 physicians since the inception of the program and their workload is continuing to increase. The Executive Committee decided to invite Dr. Martindale to the next Executive Committee meeting to discuss his ideas.
7. Dr. Charles Logan reported on a meeting he had with Dr. Raymond Scalettar, Chairman of the Board of AMA, who was in town a couple of weeks ago for one of the AMA's "Meet the Press" meeting.
8. The Executive Committee approved the attached list of direct members.

The Executive Committee of the Arkansas Medical Society on May 26, 1993, at the Arkansas Medical Society office in Little Rock. The following business was received and transacted:

1. The group discussed the need for adequate funding for the Physicians' Health Committee and suggested that Dr. Martindale obtain some information on how funding is obtained in other states and also present some information concerning an adequate budget. It was pointed out the need to define what the cost is for each physician treated by the Physicians' Health Committee. Dr. Martindale indicated he would supply some information to the Executive Committee.

There being no further business the meeting adjourned.

The Executive Committee of the Arkansas Medical Society met on June 27, 1993, at the Little Rock Hilton Inn. The following business was received and transacted:

1. Dr. Glen Baker discussed health care reform at the national and state levels. He also discussed setting up some type of managed care program for members of the Medical Society.
2. Dr. Glen Baker discussed the composition of Governor Tucker's newly formed Task Force on Health Care Reform.
3. Dr. Mike Moody discussed the inequities in the State Employee's Health Insurance Contract with UAMS and the differences in fees for urban and rural physicians.

There being no further business the meeting adjourned.

**The Executive Committee met July 28, 1993, at the Arkansas Medical Society office in Little Rock. The following business was received and transacted:**

1. The Executive Committee reviewed two proposals to do a feasibility study concerning the Medical Society setting up a managed care program. The two proposals reviewed were from Mr. Bill Loweth, Loweth Enterprises, Inc., Houston, Texas, and Peter A. Pavarini of the law firm of Schottenstein, Zox, and Dunn, Columbus, Ohio.

After reviewing both of the proposals the Executive Committee voted unanimously to engage Mr. Bill Loweth assuming that he could perform the work on a timely basis.

2. The Executive Committee approved a list of physicians for direct membership.
3. The Executive Committee discussed a proposed rule by the Arkansas Department of Health, Division of Pharmacy Services, pertaining to telephone prescriptions of controlled drugs. Several members had objections to the proposed rules because it would create some burdens on physicians who have to call in prescriptions on weekends and at night and especially those who are taking call for other physicians who may be part of a large group.

There being no further business the Executive Committee adjourned.

**The Executive Committee met following the Managed Care Committee meeting on November 22, 1993, at the Arkansas Medical Society office in Little Rock. The following business was received and transacted:**

1. The Executive Committee recommended that John E. Bell of Searcy be reappointed to the Old Congressional District #2 position on the Arkansas State Medical Board. Dr. Bell was filling the unexpired term of Dr. Lytle which ended December 31, 1993.

There being no further business the meeting adjourned.

**The AMS Executive Committee met on December 29, 1993, at the Arkansas Medical Society office in Little Rock. The following business was received and transacted:**

1. Mr. Bill Loweth, a managed care consultant with Loweth Enterprises of Houston, Texas, discussed setting up our managed care program.
2. The Executive Committee agreed to recommend that John E. Bell, M.D., of Searcy, be reappointed to the Second Congressional District on the Arkansas State Medical Board. A letter will be sent to the Governor recommending Dr. Bell for this position.
3. The Executive Committee approved a request from Dabney Brannon, M.D., of Fayetteville, for affiliate membership.

There being no further business the meeting adjourned.

**The AMS Executive Committee met on January 26, 1994, at the Arkansas Medical Society office in Little Rock. The following business was received and transacted:**

1. Dr. Rodgers recommended some minor changes be made in the Duties and Responsibilities of the Medical Services Review Committee. The Executive Committee approved them and recommended that we notify Arkansas Blue Cross Blue Shield of the changes.

The Executive Committee recommended that a letter over Dr. Lawson's signature as chairman of the committee to review the MSRC bylaws be sent to the members of the Medical Services Review Committee notifying them of these changes.

2. The Executive Committee approved writing a letter to the HCFA recommending Dr. Jan Turley for a position on the Practicing Physicians Advisory Council on Medicare.
3. A request for AMS membership from Dr. J. Fred Thomas was reviewed. It was pointed out that Dr.



Thomas did not meet all the requirements for membership. A letter was reviewed from the Medical Board that indicated Dr. Thomas holds a temporary permit. The AMS Constitution and Bylaws requires a physician to have a license. Dr. Thomas' request for membership was denied.

4. A list of physicians requesting direct membership in the Arkansas Medical Society was approved.

There being no further business the meeting adjourned.

### **Report of the Executive Vice President Ken LaMastus, CAE, Executive Vice President**

Throughout the last year the Arkansas Medical Society has continued its efforts to support and represent the physicians in the state of Arkansas.

This year we saw the settlement of the two-year Medicaid lawsuit with the Department of Human Services. David Wroten of the AMS staff provided valuable technical support to our attorneys.

The first activity of the lawsuit was a request for a temporary injunction to stop the 20% cut in the Medicaid fee schedule. Federal Judge Susan Webber Wright granted a temporary injunction for obstetric and pediatric services which was appealed to the Eighth Circuit

Court by the Department of Human Services.

The Eighth Circuit Court decided to hear the restraining order and the full legal case at the same time. The court's decision was that the AMS won the case on all the points and sent the decision back to the local judge. Judge Wright gave the Department of Human Services a period of time to develop a reasonable fee schedule. On the last day of the time allotted, DHS presented the Medicare fee schedule. The AMS and our attorneys felt this was totally inadequate and wrote a blistering response to the Judge.

What followed was a series of meetings to come to some type of agreement on the fee schedule which was done during the first part of 1994. The new fee schedule will go into effect on July 1, 1994, with the start of the state's new fiscal year. We are hopeful that with the settlement of this suit and an increase in fees, physicians of this state will be encouraged to treat Medicaid patients.

In 1993, we have seen a proliferation of managed care organizations resulting in the changing of the practice of medicine. The proliferation of managed care has caused the development of varied contractual arrangements between physicians, insurance companies, and hospitals. There was also development of several Independent Physicians Associations (IPA's).

If President Clinton has done nothing else, he has brought the issue of health care to the front burner. Managed care activity in the state is moving forward

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without national legislation but it is being developed with future national mandates in mind.

The AMS Management Company, which will organize local managed care organizations around the state, is hiring a staff at this time. Their office is located in the Arkansas Medical Society building. Janell Mason is the chief operating officer for the management company. She was the manager of Arkansas Preferred Provider Organization (APPO) in Pine Bluff (see report on the Managed Care Committee).

The AMS received an award from the AMA for recruitment efforts for 1993. The AMA set various goals and benchmarks for state medical societies and Arkansas is the only state in the nation that reached the third level of the goals. The AMS will be recognized at the annual session for those efforts.

Other projects have been ongoing in the AMS. Among the ongoing programs and efforts are those of Lynn Zeno and the Department of Governmental Affairs at the state and national levels. There is a tremendous amount of legislative and regulatory activity occurring in the state and national capitols.

Governor Tucker has appointed a Governor's Task Force on Health Care which had numerous meetings last year. Several physician leaders of the AMS are members of the task force and AMS staff members attended the meetings.

The Physicians' Health Committee chaired by Dr. Joe Martindale, continues to serve those physicians in our state who have problems with substance abuse. All physicians in the state owe Dr. Martindale and the members of the Physicians' Health Committee a great deal of respect and thanks for their efforts to help rehabilitate physicians and get them back on their career track.

From the Society staff I would like to say thank you to Dr. Glen Baker for all the hours and meetings he has attended on behalf of the Arkansas Medical Society and its members. His expertise and dedication to the Medical Society in organizing a physician owned/physician operated managed care program is appreciated. Physicians of the state never fully understand the commitment of the Medical Society officers, executive committee, and councilors. These officers and committee members contribute a tremendous amount of their time and effort.

The Society has been well served by the members of its staff this year and I am personally proud of their efforts.

## **Task Force on AIDS**

### **Joseph M. Beck II, M.D., Chairman**

The AMS Task Force on AIDS held meetings in March, May and November of 1993. Members of the Task Force have been: Drs. Joseph M. Beck II, Chairman; Jim Acklin, Susan Beland, Barbara J. Bozeman, A.

Stuart Fitzhugh, Donald C. Fournier, Charles R. Henry, William N. Jones, Linda M. McGhee and E. Clinton Texter Jr. Other members have been: Mrs. Arleta Power and Mrs. Liz Riley, AMSA representatives and Fred Church, D.D.S, Arkansas State Dental Association representative.

The number of AIDS cases continue to rise in both Arkansas and the United States. In the U.S., there have been 339,250 AIDS cases reported to the Centers for Disease Control since 1981 and 334,344 deaths (Third Quarter Edition). Since 1983, there have been 1,277 AIDS cases reported to the Arkansas Department of Health and 600 deaths (October 20, 1993 Report). At the end of 1993, there is only one Arkansas county that does not have a reported AIDS case. Task Force members have continued to speak at schools, churches, civic groups and hospital staff meetings across the state in order to continue emphasis on education.

During 1993, the AMS Task Force on AIDS corresponded frequently with the Arkansas State Medical Board regarding Regulation 16, which required physicians to report their HIV positive status to the Board. The Task Force has expressed its reservations concerning Regulation 16 because they feel that physicians will be reluctant to be tested.

At this time, the AMS Subcommittee on Bloodborne Diseases is discussing with the Board if it would serve as an instrument for review and counseling of physicians affected by this regulation. The proposal is that the Board would defer disciplinary action unless the physician was not complying with the Subcommittee's recommendations. The Subcommittee has indicated that it would serve in that capacity if it was officially named in the regulation.

During the 79th General Assembly, the AMS supported HCR 1017 introduced by Representative Lacy Landers, et al, which expressed opposition to the proposal to remove HIV infection from the list of communicable diseases for the purpose of immigration. The resolution passed the House and the Senate. The AMS Council reaffirmed the Society's position on keeping a ban on HIV infected persons wanting to immigrate to the United State. A copy of the resolution was sent with a letter by Dr. Jones to the Arkansas Congressional Delegation, the American Medical Association and the state medical association presidents.

Other AIDS related legislation included ACT 438 of 1993, which authorized the court to order AIDS testing for criminals transferring bodily fluids to law enforcement officers or EMTs, and ACT 616 of 1993, which authorized the court to order a HIV test if a sexual crime victim requests it.

The Task Force is currently working on the 1994 AIDS Feature Session, which will be held Saturday, April 9, 1994 at the Excelsior Hotel in Little Rock. The keynote speaker will present information in the morn-



ing session and there will be mini-sessions in the afternoon on such issues as TB, anti-viral therapy and when to use certain drugs, pulmonary manifestations, contact tracing and partner notification, women and HIV and the economic impact on AIDS on Arkansas.

The Society is represented on the Arkansas Department of Health's AIDS Advisory Board by Dr. Jones and Dr. Beck. The AIDS Advisory Board meets monthly to discuss policy and regulations concerning HIV disease.

As in previous years, the monthly AIDS and HIV statistics and the quarterly reports were printed in *The Journal of the Arkansas Medical Society* because the Task Force felt it is vital that the Society members receive this information. The following articles were published in *The Journal* in 1993:

*Racial Minorities at Increased Risk - An Arkansas HIV/AIDS Report: Autumn, 1992, Arkansas Department of Health, January, 1993.*

*New AIDS Case Definition, Arkansas Department of Health, July, 1993.*

*Tuberculosis and HIV Infection, Joseph M. Beck II, M.D., September, 1993.*

*Diagnosis, Care and Management of the Pediatric HIV/AIDS Patient in Arkansas, Nancy C. Tucker, R.N., Gordon E. Schutze, M.D., Toni Darville, M.D., and Richard F. Jacobs, M.D., November, 1993.*

## **Tenth Councilor District**

**Morton Wilson, M.D., Gerald Stolz, M.D.  
and Paul Wills, M.D., Councilors**

The year 1993 proved to be an active year politically for the Tenth Councilor District of the Arkansas Medical Society. Monthly meetings of the component county medical societies were frequently the forum for fruitful discussions of the many socioeconomic issues facing medicine in the immediate future.

A combined meeting of the Sebastian County Medical Society and Auxiliary was addressed by Dr. Joycelyn Elders, former director of the Arkansas Department of Health and present U.S. Surgeon General on March 16, 1993.

At the April 13, 1993 meeting of the Sebastian County Medical Society, the membership voted to endorse PASS (People Against Second-hand Smoke) in their efforts to pass an ordinance to ban smoking in enclosed public places in the city of Fort Smith. Dr. Paul Wills has been one of the leaders of this organization. Unfortunately, in the election held on January 24, 1994, the measure failed to be approved by a mere 300

votes of the over 13,000 cast.

On September 14, 1993, members and wives of the Sebastian County Medical Society met at a dinner meeting with local state representatives and senators to host an open discussion on questions of concern to the medical profession.

At the October 12, 1993 meeting of the society Ms. Nancy Kintzel of the AMA's Legislative Liaison Committee reported on the AMA's position on President Clinton's proposed health care reform and the AMA's campaign for their version of this reform.

U. S. District Federal Judge Jim Hendron addressed the November 9, 1993 meeting on the need to promote understanding between the legal and medical communities.

The Pope County Medical Society sponsored a meeting in early 1993 for members and spouses/guests at which Dr. Larry Lawson, President of the Arkansas Medical Society, spoke to the membership about "Current Political Issues".

Through the efforts of many members and coordination by Dr. Don Riley, current president of the Pope County Medical Society, we hopefully helped defeat the provider tax bill which was proposed in the legislature; a concept of taxation which would have been and remains an onerous impractical theory of taxation.

In March 1993, Drs. James Kolb and Gerald Stolz and other physicians attended the AMA sponsored meeting in Washington, D.C., to learn of the various health care proposals being considered by the Clinton Administration and Congress.

The councilors of the Tenth District recognized that in order for the component societies to provide the best possible medical leadership, we sincerely urge members in this districts to be cognizant and responsive to the spectrum of continuous change in health care delivery.

## **Young Physicians Committee Anna Ridling, M.D., Chairman**

The Young Physicians Committee is gearing up to initiate a new era of activity among the young physicians in Arkansas. Young physicians now constitute 31% of the total membership of the Arkansas Medical Society. If students and residents are included they comprise 50% of the membership. The committee is planning several items to stimulate membership and participation in the Society among these groups.

The committee is updating and conducting a survey of young physicians to try and target their concerns and interests, so they may be addressed by the committee and the Society.

We plan to develop an orientation program for new delegates, new members, and first time attendees at

the spring meeting. We will also be hosting a hospital-ity hour for young physicians to give them an opportunity to meet each other and some of the leadership.

We are developing a communication network between our committee and the Young Physicians Section of surrounding states. This will give us the means to share ideas and concerns with other young physicians in similar geographic locations, who may be facing the same problems.

We have mandated the committee meet at least bi-annually to conduct business and promote membership and leadership among the young physicians of Arkansas. Eventually, we plan to have specific activities for young physicians, either as a precursor to, or in conjunction with, the state meetings.

As chairman, I attended the AMA's Young Physicians meetings in June and December. The committee decided to recommend that a delegate and alternate delegate be sent to future AMA-YPS meetings to facilitate national networking and provide continuity in the leadership of the Young Physicians Committee. We have also requested that a member of the Resident Physician Section and Medical Student Section be ex-officio members of our committee.

Our committee has many ideas and plans for recruitment, retention, and leadership development. These are being discussed currently and will be implemented when approved and the logistics resolved. We appreciate the support of the Council and the AMS staff in our endeavor to pursue the goals of the Young Physicians Committee.

**Arkansas State Medical Board**  
**Peggy Pryor Cryer, Executive Secretary**

The members and officers of the Arkansas State Medical Board are W. Ray Jouett, M.D., Chairman; Warren M. Douglas, M.D., Vice Chairman; Alonzo D. Williams, M.D., Secretary; Mr. John Currie, Sr., Treasurer; John E. Bell, M.D., Owen H. Clopton, M.D., Steven F. Collier, M.D., Mr. Ted J. Feimster, David C. Jacks, M.D., Linda A. McGhee, M.D., C. E. Tommey, M.D., Rhys A. Williams, M.D., and James Zini, D.O.

Dr. Asa Crow who had served since 1989 resigned in June of 1993. Mr. Dewey Lantrip, a consumer member of the Board died in August after serving on the board for eleven years.

The board approved the use of the United States Medical Licensing Exam (USMLE). The exam which was first given in 1992 will be administered by the board in June of 1994. The USMLE replaces both the Federal Licensing Exam (FLEX) and the National Board Medical Exam (NBME).

The first issue of the Medical Board's newsletter was published in the summer of 1993. This newsletter was designed to keep physicians abreast of changes within the regulations and laws by which they must

comply, as well as board actions against physicians and other health care professionals licensed by this board. There will be informative articles pertinent to the practice of medicine.

Licensing statistics: medical doctors and doctors of osteopathy - 7,161; medical doctors and doctors of osteopathy who practice in the state - 4,287; occupational therapists - 458; occupational therapist assistants - 61; physician trained assistants - 37; respiratory care therapists - 201; medical doctors and doctors of osteopathy licensed in 1993 - 414; medical doctors and doctors of osteopathy who sat for the FLEX exam - 123; medical doctors and doctors of osteopathy who sat for the SPEX exam - 6.

Summary of the Board's proceedings for 1993: individual complaints and discussions - 211; show cause orders issued - 7; voluntary surrender of license - 2; emergency order of suspension - 2; suspended license - 3; license placed on probation - 2; license revoked - 5; cases forwarded to the AMFC - 1; fined - 1; physicians requested to appear to further explain complaints - 10; physicians required to notify board before moving back to this state - 3.

Public hearings were held on the following regulations: Regulation 16 - physicians, HIV and HBV; Regulation 15 - nurse practitioner regulation and supervision (repealed); Regulation 6 - occupational therapist (amended); Regulation 4 - physician trained assistants (amended); and Regulation 14 - examinations (amended). A hearing was held on all changes within the statutes and regulations since the inception of the Board.

**Financial Report - June 30, 1993**

<u>Current assets</u>	
Cash	\$633,840
Certificates of deposit	716,247
Accrued interest receivable	6,356
<b>Total current assets</b>	<b>\$1,356,443</b>

<u>Fixed assets - at cost</u>	
Furniture, fixtures, and equipment	\$77,566
Less accumulated depreciation	(37,735)
<b>Net fixed assets</b>	<b>\$39,831</b>

<b>Total assets</b>	<b>\$1,396,274</b>
---------------------	--------------------

Liabilities and Fund Balances

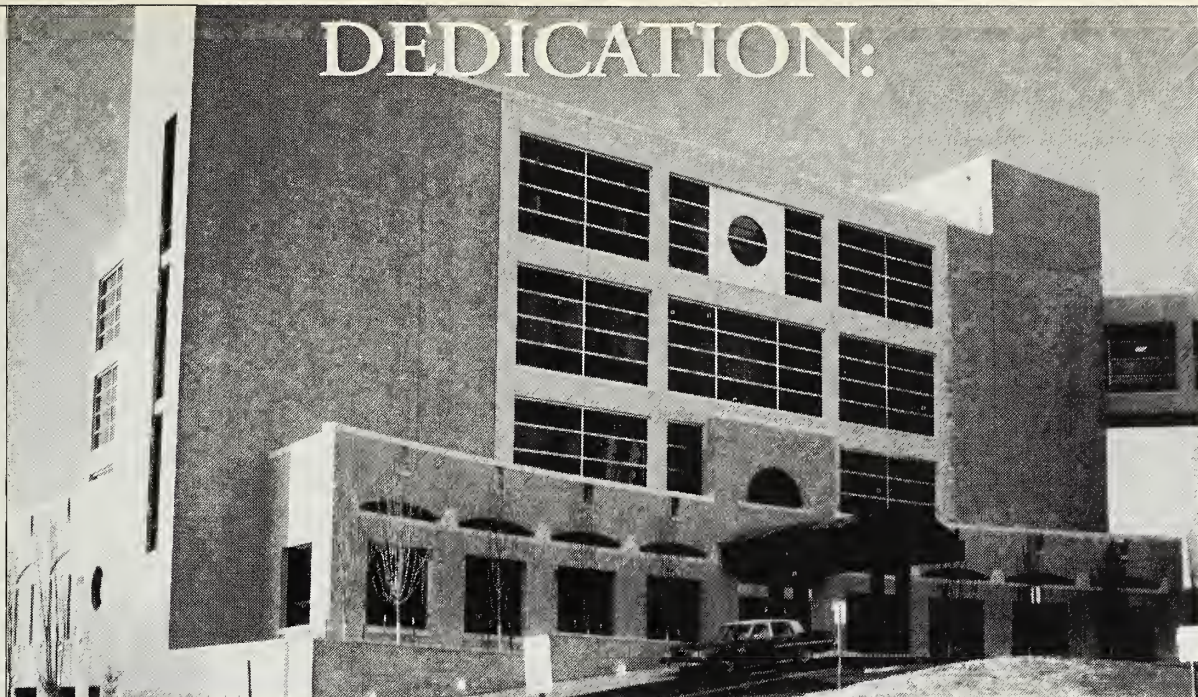
<u>Current liabilities</u>	
Accounts payable	\$6,435
Deferred income	49,833
Accrued payroll taxes	267
Accrued wages	3,548
Accrued unused vacation pay	5,997
<b>Total current liabilities</b>	<b>\$66,080</b>

<u>Fund Balances</u>	\$1,330,194
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<b>Total Liabilities and Fund Balances</b>	<b>\$1,396,274</b>
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# DEDICATION:



Dedication Ceremonies will be held Friday, April 8, 1994 in Little Rock, Arkansas to formally open the doors of the new Harvey & Bernice Jones Eye Institute on the campus of the University of Arkansas for Medical Sciences. This historic event will include an important Scientific Session on the topic of:

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Bascom-Palmer Eye Institute  
University of Miami School of Medicine, Miami, Florida

**Joe G. Hollyfield, Ph.D.**  
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Cullen Eye Institute  
Baylor College of Medicine, Houston, Texas

**David Weeks, President**  
Research to Prevent Blindness, New York, New York

**John P. Shock, M.D., Program Director**  
Professor/Chairman of Ophthalmology  
Jones Eye Institute, Little Rock, Arkansas

If you would like additional information on the Jones Eye Institute Scientific Session/Dedication, or any of the Institute's clinical, research or educational programs, please call 501/686-5150.



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## **Report of the Arkansas Department of Health to the Arkansas Medical Society**

### **Tom Butler, Deputy Director of Administration**

It is my privilege to present to the Society a report on the accomplishments and activities of the Arkansas Department of Health during 1993. It has been a year marked by change, with the departure of Dr. Joycelyn Elders for the post of U.S. Surgeon General, and the Department's involvement in planning for health care reform. It has also been a year of continued public health service to the citizens of Arkansas.

Public health in Arkansas depends on many partnerships to respond to the scope of public health needs. The partnership we enjoy with the Arkansas Medical Society and its members is critical to our ability to provide clinical preventive services, care for in-home patients, and improve our State's health care delivery system. As partners in public health, we want you to share in the successes we experienced this year.

#### **Personal Health Services**

- Expanded Hospice care to two additional management areas, making this service available through the Department of Health in 35 counties.
- Established the Community Women's Clinic at the Pulaski County Central Health Unit in collaboration with UAMS. This clinic provides comprehensive women's health services, including family planning and prenatal care.
- Registered an 8% reduction in the teen fertility rate and a 21.4% reduction in the teen abortion rate in Arkansas between 1990 and 1992.
- Expanded family planning services through increased state funding for contraceptive services, including Norplant and tubal ligations.
- Provided breastfeeding promotion and problem management training to 440 health professionals and responded to over 200 phone calls a month about breastfeeding problems and concerns.
- Increased WIC caseload by 7,322 average participants per month. WIC is now serving 79.3% of eligible participants in Arkansas.
- Increased the percent of breastfeeding WIC participants from 5% to 7% between 1992 and 1993.
- Developed and implemented a Maternal and Infant Home Visiting Program for pregnant women and their infants.

- Expanded the Campaign for Healthier Babies with the implementation of the coupon incentive phase. This Campaign component provides mothers with a book of money-saving coupons which can be redeemed only after she has been provided prenatal care. The Campaign for Healthier Babies is a joint effort with the Arkansas Department of Human Services, Arkansas Advocates for Children and Families, March of Dimes (Arkansas Chapter), KATV (ABC), UAMS High Risk Pregnancy Program, and several other hospitals and media sponsors. The campaign's goal is to increase the number of pregnant women who receive early and regular prenatal care.
- Developed and implemented a four day training program for public health nurses regarding maternity services. This course, offered three times a year, will eventually serve to orient all new public health nurses to maternity clinics and ensure that staff working in health department prenatal clinics maintain a high level of knowledge and expertise.
- Worked with the UAMS High Risk Pregnancy Program in the development of the Perinatal Education Resource and Learning System (PERLS). PERLS is a series of 18 self study modules which can be used as inservice for perinatal health professionals.
- Established an Adolescent Health Steering Committee to coordinate planning efforts for service delivery from an adolescent specific health perspective.
- Implemented a joint project for comprehensive school health services with the Arkansas Department of Education, funded by a cooperative agreement from the Centers for Disease Control and Prevention.
- Provided health screenings and immunizations to approximately 2,000 preschoolers in the Arkansas Better Chance Program through a contract with the Arkansas Early Childhood Commission.
- Established a Tobacco Prevention and Control Office, funded by a cooperative agreement with the Centers for Disease Control and Prevention to work on comprehensive tobacco control strategies.
- Formed a statewide cancer coalition to develop a state cancer control plan.





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- Implemented an oral rehydration therapy project, funded by the Centers for Disease Control and Prevention to reduce the number of hospitalizations due to diarrheal disease in children in the Delta.
- Expanded TB screening and surveillance programs to include prisons, jails, homeless shelters and drug treatment centers.
- Revised the Rules and Regulations for TB Control to require tuberculosis screening of employees and residents in high risk populations.
- Established consortia in five areas throughout the state to provide care to HIV-infected patients.
- Documented the first reduction in sexually transmitted disease in two years. The number of syphilis cases decreased from 2,392 cases to 1,673 cases; the number of gonorrhea cases decreased from 9,120 cases to 6,587.
- Implemented an influenza program in local health units, resulting in the provision of 81,362 doses of flu vaccine by December, 1993.
- Implemented a statewide policy to offer immunizations on a "walk-in" basis in local health units.
- Collaborated with civic organizations, community groups, service providers, the media, and other state agencies to develop and implement an immunization action plan to improve immunization rates of children under 2 years of age in Arkansas.
- Developed a media campaign, "Shots for Tots", with KATV (ABC) and TCBY to promote immunizations by offering free yogurt to children who received their shots.
- Awarded \$540,000 through Prevention Services Program grants to 26 community-based non-profit organizations to implement prevention activities of their design, targeting high-risk youth.
- Awarded \$181,000 for four Community Youth Activity grants in the Delta Region of Arkansas to create minority specific prevention activities.
- Awarded three grants totaling \$280,000 for substance abuse treatment for pregnant and parenting women's living centers.
- Continued three pilot Street Outreach Programs

in Washington, Pulaski and Jefferson Counties to address the growing crisis related to injection drug users and HIV/AIDS transmission.

- Issued a grant for a pilot Injector Drug User Clinic to be operated by the University of Arkansas for Medical Sciences. The clinic will offer methadone as an adjunct to treatment.
- Provided support to the New Futures for Little Rock Youth Program, funded by the Annie B. Casey Foundation, to fund summer employment and other projects which provide social activities targeting high-risk youth.
- Admitted 95 youth during FY 93 to the state's only specialized comprehensive adolescent treatment facility, Western Arkansas Counseling and Guidance-Horizon Program. Twenty-nine (29) of these youth successfully completed treatment with no substance abuse.

#### **Services to Protect the Environment and Health of the General Public**

- Achieved passage of Act 903 of 1993 establishing a fee of \$0.25 per month per water service connection to be used for implementing the 1986 Safe Drinking Water Act (SDWA) Amendments.
- Completed SDWA-required testing for lead and copper in 654 small and medium watersystems resulting in a compliance rate better than the national average. Arkansas is one of few states that has completed SDWA-required lead copper monitoring on schedule.
- Initiated expanded monitoring for herbicides, pesticides, nitrates and inorganics as required by SDWA regulations.
- Provided drinking water education to over 12,000 primary and middle school students through "Water Wizard" programs, conducted by the Division of Engineering.
- Developed a marine sanitation compliance program regulating disposal of sewage from approximately 5,000 houseboats.
- Amended food service, food store and market regulations. Among the amendments is required compliance with the Synar amendment regarding the sale of tobacco to minors.



**Table 1**  
**Personal Health Services**  
**Selected Statistics**

Service	FY 1992 July 1, 1991 - June 30, 1992	FY 1993 July 1, 1992 - June 30, 1993
<b>Family Planning</b>		
Patients	64,724	67,820
Visits	138,286	143,291
<b>Maternity</b>		
Patients	14,695	15,985
Visits	60,078	66,000
<b>Cancer</b>		
Cervical Screenings	52,873	52,978
Mammograms	300	268
<b>WIC Clients</b>		
Served	121,048	140,434
<b>Child Health</b>		
Visits	85,093	70,419
<b>Early Periodic Screening Diagnosis and Treatment (EPSDT)</b>		
Screenings	59,038	60,094
<b>Blood Lead</b>		
Screenings	12,260	15,505
<b>Hearing</b>		
Screenings	221,553	219,007
<b>Vision</b>		
Screenings	249,253	218,777
<b>Immunizations (doses)</b>		
Polio	113,388	114,057
Diphtheria, Tetanus, Pertussis (DPT)	136,417	138,294
Measles, Mumps, Rubella (MMR)	45,909	46,125
Haemophilus Influenzae Type b (HIB)	102,829	99,293
<b>AIDS</b>		
Testing and counseling	41,644	56,020
<b>Substance Abuse Treatment</b>		
Clients Served	13,468	13,879
Adolescents Served	843	834
<b>In Home Services</b>		
Patient admissions	17,396	19,393
<b>Recovering Patient visits</b>	386,146	465,999
Chronic Patient visits	27,351	35,334
Frail Patient hours	1,238,240	764,602
Hospice patient days	6,730	7,818



- Implemented Food Service Manager Training, providing the nationally certified "Applied Food Service Sanitation Course" of the National Restaurant Association.
- Developed and implemented regulations pertaining to the processing of bottled drinking water for both in-state and out-of-state bottled water manufacturers.
- Implemented changes in methodology for tuberculosis testing resulting in lowering the identification time by 50%.
- Initiated the DNA-probe method of testing for gonorrhea eliminating the need for incubating most specimens which simplified the submission of specimens to the laboratory.
- Assured local health unit compliance with the Clinical Laboratory Improvement Amendments (CLIA). On-site education, training and proficiency testing are routinely performed to assure the health units' ability to perform a limited number of tests in the waived and moderate complexity categories.
- Continued to comply with federal laws regarding development of a regional low-level radioactive waste disposal site in Nebraska. Arkansas' Director of Radiation Control is a member of the Central Low-Level Radioactive Waste Compact Commission and was Chair until June, 1993.
- Continued to provide information and technical assistance to the public regarding radon health risks, testing procedures and mitigation techniques. A recently published EPA map of radon zones indicates that Arkansas is among those states with the lowest average level for radon in the nation.

**Table 2**  
**Services to Protect the Environment and Health of the General Public**  
**Selected Statistics**

Service	FY 1992 July 1, 1991 - June 30, 1992	FY 1993 July 1, 1992 - June 30, 1993
<b>Food Service Establishment</b> Inspections	31,353	26,206
<b>Septic Tank</b> Inspections	7,531	8,034
<b>Radiological Equipment</b> Inspections	464	608
<b>Laboratory Samples</b> Analyzed	456,254	480,366
<b>Environmental Complaints</b> Investigated	6,865	7,390
<b>Wastewater and Wastewater Plans</b> Reviewed	1,578	2,514



- Updated the Radiological Protection annexes in the State Emergency Operating Plan and in 18 local Emergency Operating Plans.
- Intensified efforts by the Radiological Defense Program in the maintenance and calibration of 20,732 radiological monitoring instruments deployed throughout the State. This equipment is on loan from the Federal Emergency Management Agency for use in the event of a nuclear disaster.
- Participated in a Radiological Emergency Response Exercise and two quarterly drills for Arkansas Nuclear One (Russellville) in a five-county area surrounding the site.
- Developed and implemented cross connection training and backflow device certification to insure plumbing systems are not a threat to public drinking water.
- Continued to develop the regulation of heating, air conditioning, ventilation and refrigeration systems in an effort to reduce illness caused by poor indoor air quality.
- Initiated efforts to adopt a restricted plumber's license specifically for water softeners and water treatment systems.
- Implemented training and certification for the fusion of plastic gas piping.

#### Developing Health Systems to Insure Health Care Access

- Effective July 1, 1993, the Division of Alcohol and Drug Abuse Prevention (ADAP) of the Department of Human Services became a part of the Department of Health. ADAP, now known as the Bureau of Alcohol and Drug Abuse Prevention was created by Act 644 of 1977. ADAP is responsible for the coordination of activities and administration of funds for all state and federally supported substance abuse programs in Arkansas. It provides funding, technical assistance, consultation, planning and resource development services to community-based substance abuse programs, who in turn, provide direct services to the community. The Bureau also operates a state-wide alcohol and drug detoxification unit, a film and resource library, a speakers bureau and a training system available to all citizens.

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

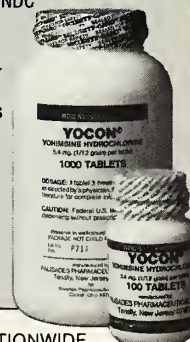
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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- Received a two year federal grant to begin Trauma System development.
- Act 1146 of 1993 names the Division of Pharmacy and Drug Control as the sole investigators for the Medical Board.
- The Health Department established a newborn infant hearing screening program as mandated by Act 1096 of 1993.
- Act 41 of 1992 authorized the Department of Health to regulate the segregation, packaging, storage, transportation, treatment and disposal of commercial medical waste. There are currently 17 transporters registered to transport commercial medical waste in Arkansas.
- Act 537 of 1989 established the Utilization Review Program to certify private review agents (insurance carriers, utilization review companies, third party administrators, peer review organizations) to perform utilization review in Arkansas. The Act also requires that plans for certification be evaluated with regard to their ability to address medical necessity, appropriateness and efficiency in use of health care services, procedures and facilities.
- Act 763 of 1993 established the Rural Physician Incentive Program to encourage physicians to locate and remain in the practice of family medicine in critically underserved rural Arkansas communities that have a population of 15,000 or less, or in a medically underserved area as designated by the U.S. Department of Health and Human Services.

## Doctors Day March 30, 1994

Thank you, Arkansas Doctors,  
for the care you've given.

- Completed construction of Local Health Unit in Van Buren County (Clinton) and renovated Washington County (Fayetteville) Health Unit for a HIV Clinic. Both projects were funded through the Local Grant Trust Fund (Board of Health).

As we look toward 1994, we will continue to maximize our resources to protect and improve the health of Arkansans. And, as we all look toward significant change in health care delivery through health care reform, we look forward to a continued partnership with you to assure affordable, accessible, high-quality health care for our citizens.

**Table 3**  
**Developing Health Systems to Insure Health Care Access**  
**Selected Statistics**

Service	FY 1993 July 1, 1992 - June 30, 1993
<b>Utilization Review</b> Number of Review Agents Certified	131
<b>Rural Health Services Revolving Fund</b> Number of communities funded during the last funding cycle	14
<b>Rural Physician Incentive Program</b> Number of physicians	30



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as of February 18, 1994

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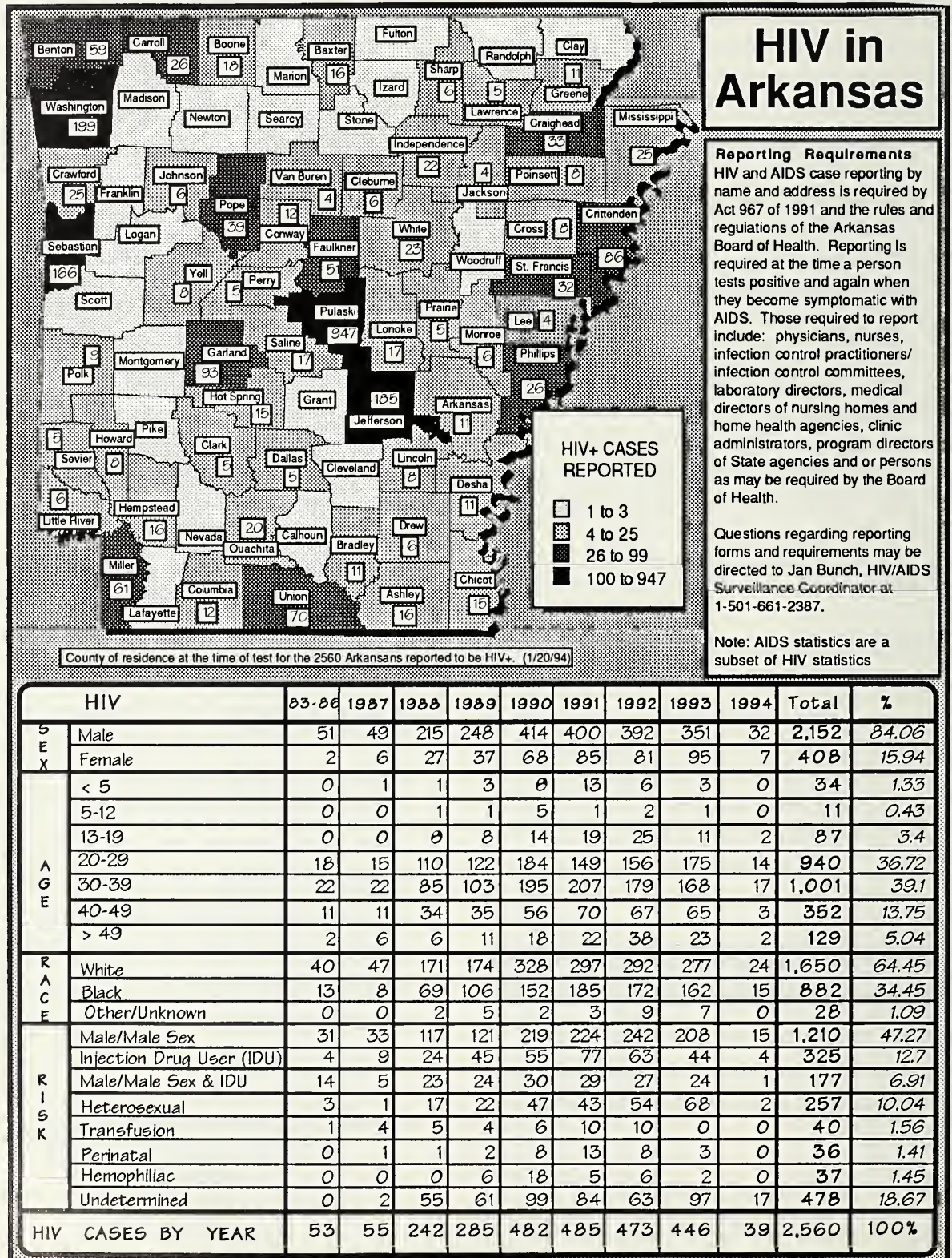
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# Arkansas HIV/AIDS Report

## 1983-1993



Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1993

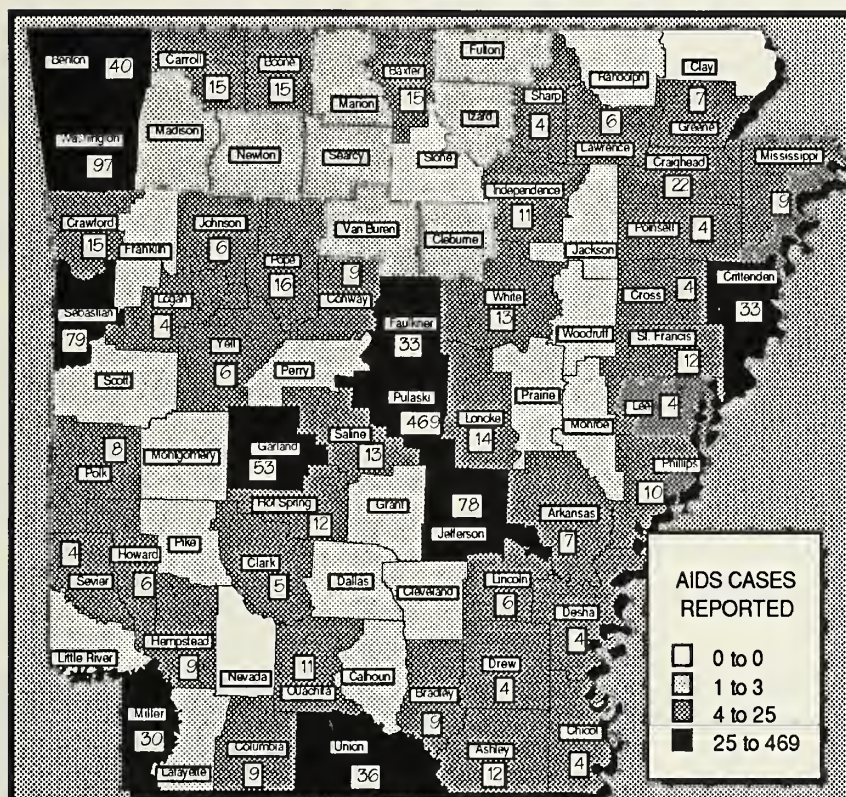
### AIDS in Arkansas

#### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Act 967 of 1991 and the rules and regulations of the Arkansas Board of Health. Reporting is required at the time a person tests positive and again when they become symptomatic with AIDS. Those required to report include: physicians, nurses, infection control practitioners/infection control committees, laboratory directors, medical directors of nursing homes and home health agencies, clinic administrators, program directors of State agencies and or persons as may be required by the Board of Health.

Questions regarding reporting forms and requirements may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator at 1-501-661-2387.

Note: AIDS statistics are a subset of HIV statistics



Of the 2560 Arkansans reported to be HIV+, 1352 have been diagnosed with AIDS. (1/20/94)

AIDS		83-86	987	1988	1989	1990	1991	1992	1993	1994	Total	%
SEX	Male	39	46	77	70	170	176	250	335	22	1,185	87.65
	Female	1	4	6	10	20	25	35	65	1	167	12.35
AGE	< 5	0	0	1	1	6	6	3	2	0	19	1.41
	5-12	0	0	1	0	1	1	0	1	0	4	0.3
	13-19	0	0	0	0	4	3	2	4	0	13	0.96
	20-29	16	15	27	24	55	57	81	110	2	387	28.62
	30-39	16	23	36	41	78	80	128	178	13	593	43.86
	40-49	7	8	10	7	35	41	52	78	5	243	17.97
	> 49	1	4	8	7	11	13	19	27	3	93	6.88
RACE	White	31	43	61	58	141	134	206	275	16	965	71.38
	Black	9	7	20	21	47	66	75	121	7	373	27.59
	Other/Unknown	0	0	2	1	2	1	4	4	0	14	1.04
RISK	Male/Male Sex	24	31	59	50	120	120	179	215	17	815	60.28
	Injection Drug User (IDU)	2	10	4	11	18	29	43	57	4	178	13.17
	Male/Male Sex & IDU	12	4	6	6	18	17	19	24	1	107	7.91
	Heterosexual	2	2	3	6	10	9	25	45	0	102	7.54
	Transfusion	0	2	7	3	7	11	3	2	0	35	2.59
	Perinatal	0	0	1	1	6	6	3	3	0	20	1.48
	Hemophiliac	0	0	1	1	5	5	4	5	0	21	1.55
	Undetermined	0	1	2	2	6	4	9	49	1	74	5.47
AIDS CASES BY YEAR		40	50	83	80	190	201	285	400	23	1,352	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# New Members

---

## CAMDEN

**Shrestha, Bal N.**, General Surgery. Medical education, Nagpur Medical College, India, 1962. Residency, Meharry Medical College, Nashville, Tenn., 1986.

## CHEROKEE VILLAGE

**Ablog, Angel D.**, General Practice. Medical education, University of Santo Tomas, Manila, Philippines, 1963. Internship/Residency, Grace General Hospital, 1968.

**Graham, Paul A.**, General Surgery. Medical education, Columbia University, New York, 1961. Internship, University Hospital of Cleveland, 1962. Residency, Walter Reed General Hospital, 1968. Board certified.

## CONWAY

**Almond, Cynthia C.**, General Practice. Medical education, UAMS, 1979. Internship, UAMS, 1980.

## DIERKS

**Shefa, Bobbie**, General Practice. Medical education, UAMS, 1973. Internship/Residency, Methodist Hospital of Dallas, 1975.

## EL DORADO

**Jucas, John J.**, Dermatology. Medical education, UAMS, 1974. Internship, Tripler Army Medical Center, Hawaii, 1975. Residency, Brooke Army Medical Center, Texas, 1980. Board certified.

## FORT SMITH

**Hewett, Mark A.**, Urology. Medical education, UAMS, 1983. Internship, University Hospital, 1984. Residency, UAMS, 1989. Board certified.

## HOT SPRINGS

**Gammill, Todd D.**, Cardiology. Medical education, UAMS, 1979. Residency, Washington University School of Medicine and St. Luke's Hospital, St. Louis, 1984. Board certified.

**Lemay, Thomas B.**, Cardiology. Medical education, UAMS, 1986. Internship/Residency, UAMS, 1989. Fellowship, UAMS, 1993. Board certified.

**Sloand, Timothy P.**, Orthopaedic Surgery. Medical education, University of Rochester School of Medicine, New York, 1988. Internship/Residency, University of North Carolina, Chapel Hill, 1993. Board pending.

## JONESBORO

**Owen, Kaye K.**, Orthopedic Surgery. Medical education, Texas A & M College of Medicine, College Station, Texas, 1988. Internship/Residency, UAMS, 1993. Board eligible.

**Sanchez-Carmichael, Ilsa**, General Practice. Medical education, Universidad Central del Caribe Escuela de Medicina de Cagiez, 1983. Internship Bayamon Regional Hospital, 1985.

## LITTLE ROCK

**Anderson, Roger W.**, Otolaryngology. Medical education, West Virginia University, Morgantown, 1975. Internship, Akron City Hospital, 1976. Residency, West Virginia University Hospital, 1979. Board certified.

**Burba, Alonzo R.**, Neurology. Medical education, University of Oklahoma, Oklahoma City, 1976. Internship, Dewitt Army Hospital, Virginia, 1977. Residency, Texas Tech HSC, Lubbock, Texas, 1993.

**O'Keefe, Dorothy A.**, Child & Adolescent Psychiatry. Medical education, SYNY, Upstate Medical Center, Syracuse, New York, 1983. Internship/Residency, Walter Reed Army Medical Center, Washington, D.C., 1987. Fellowship, Walter Reed Army Medical Center, 1989. Board certified.

## MOUNT IDA

**Larey, Mark E.**, Internal Medicine. Medical education, Kirksville College of Osteopathic Medicine, 1986. Internship, Dallas Family Hospital, 1987. Residency, Doctors Hospital, 1990. Board certified.

## PEA RIDGE

**LeBoeuf, Dorothy F.**, Family Practice. Medical education, University of Missouri, Columbia, 1962. Internship, Pontiac, Michigan, 1963. Board certified.

**Morgan, Martha K.**, Family Practice. Medical education, UAMS, 1984. Internship/Residency, Southern Illinois University, Belleville, Ill., 1987. Board certified.

## PINE BLUFF

**Quimosing, Estelita M.**, Internal Medicine-Infectious Diseases. Medical education, University of Santo Tomas, Philippines, 1974. Internship/Residency, University of Santo Tomas, 1979, and University of Illinois, 1991. Fellowship, Tulane University Medical Center, 1993.



## STAR CITY

Lewellen, Thomas L., Family Practice. Medical education, Chicago College of Osteopathic Medicine, 1979. Internship, Garden City Osteopathic, Michigan, 1980. Board certified.

## OUT OF STATE

Carlisle, David L., Anesthesiology, Texarkana, Texas. Medical education, University of Texas Medical Branch, Galveston, Texas, 1976. Internship/Residency, UAMS, 1979.

Schwartz, Joseph C., Ophthalmology, Memphis, Tenn. Medical education, University of Maryland, Baltimore, 1988. Internship, Mercy Medical Center, Baltimore, 1989. Residency, Washington Hospital Center, Washington, D.C., 1992. Board pending.

## RESIDENTS

Simpson, Todd R., Family Practice. Medical education, University of Osteopathic Med. & Health Sciences, Des Moines, Iowa, 1992. Residency, UAMS/AHEC-Northwest, Fayetteville.

## STUDENTS

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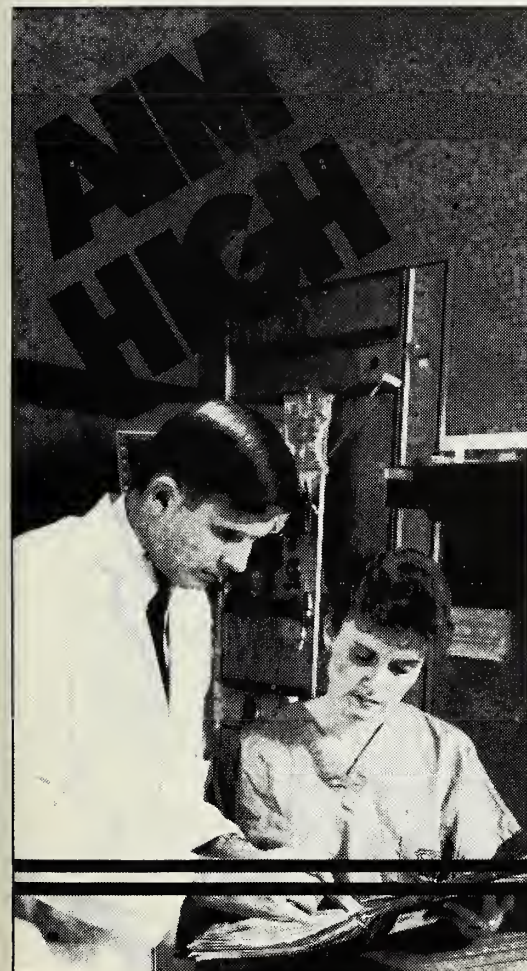
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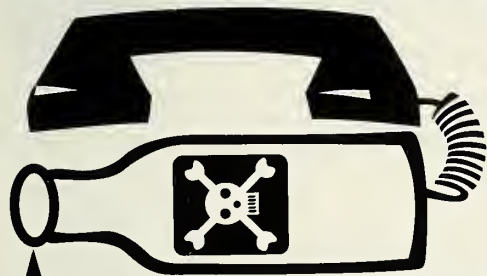


## Poison Control Center Has a New Telephone Number

Since 1976 the University of Arkansas for Medical Sciences College of Pharmacy, through its Arkansas Poison & Drug Information Center, has been serving health-care providers in Arkansas with emergency toxicological information (poisonings) and pharmacological information concerning drug therapy.

Over the years the Center has received more and more calls from the general public. During the last Legislative session the Arkansas Poison Control Center was established by the Arkansas Legislature in order for us to expand to a public access, statewide poison control center. Therefore, effective January 1, 1994, the Arkansas Poison Control Center has changed its number and we encourage both the general public and health professionals to use this number for poisoning information. The new number is 1 (800) 3POISON [1-800-376-4766]. The old number, (800) 462-8948, will still be available for health professionals; however, we do encourage even the health professionals to use the (800) 3POISON number.

# POISON HOTLINE



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## VHA Offers Highly Rated Video on TB Control

Tuberculosis has reemerged as the world's most infectious disease. An estimated 10 million to 15 million people in the United States carry TB, and the number of active cases has been on the rise. Just as worrisome, occupational exposures to drug-resistant TB may also be on the rise, but many health-care providers do not have adequate programs in place to track exposure, according to the National Centers for Disease Control and Prevention.

Voluntary Hospitals of America Inc. has entered the battle against TB with the production of a video designed to help health-care professionals everywhere improve patient care, guard against occupational exposure and establish effective infection-control methods.

The video, "The New Face of Tuberculosis," which originally aired as a live videoconference for VHA hospitals, received high marks from the National Foundation for Infectious Diseases.

"This video should be viewed by all physicians, nurses and health-care personnel," said Richard J. Duma, M.D., Ph.D., executive director of the NFID. "The video is timely, contemporary and concerns itself with virtually every clinical and epidemiological aspect of the disease, especially risks, prevention, therapy . . . and handling tuberculosis in the hospital."

The 90 minute video features four tuberculosis experts who explain how to diagnose, isolate and treat patients to minimize occupational exposure, identify high-risk procedures and create an institution wide TB exposure-control plan. The video also discusses the federal guidelines and regulations that relate to TB infection control.

The TB educational package costs \$150. To order a copy, physicians and other health professionals can call (800) 358-4352. The package includes the video and an accompanying workbook that contains a sample of an airborne-pathogen exposure-control plan.

## Doctors Hospital Awarded ADA Recognition

The Diabetes Treatment Center at Doctors Hospital in Little Rock was recently awarded the American Diabetes Association Certificate of Recognition for its quality diabetes patient education program. The program is one of only two programs in the state that have been recognized by ADA. Diabetes affects approximately 150,000 Arkansans.

# YOU MAKE THE DIFFERENCE!



In Arkansas, hundreds of physicians, pharmacists, dentists, home health agencies, hospitals and public health agencies have joined forces to support the Arkansas Health Care Access Foundation, Inc. (AHCAF). These providers are part of a unique voluntary effort to provide access to quality health care for low-income Arkansans who do not qualify for government assistance, have no form of health insurance and are living at or below the federal poverty level.

**You can help!** Thousands of Arkansans are potentially eligible for this safety net program. Therefore, continued support from all sectors of the health care community is essential if we are to meet the growing demand. Volunteering your services ensures timely medical attention for those in need. **You make a difference!**

Since 1989 AHCAF has reached thousands of people and led, by example, in the quest for broader access to medical care. And with your continued support we will ensure the health and welfare of all Arkansans.

For more  
information  
on how  
you can help,  
call AHCAF at  
(501) 221-3033  
or (800) 950-8233



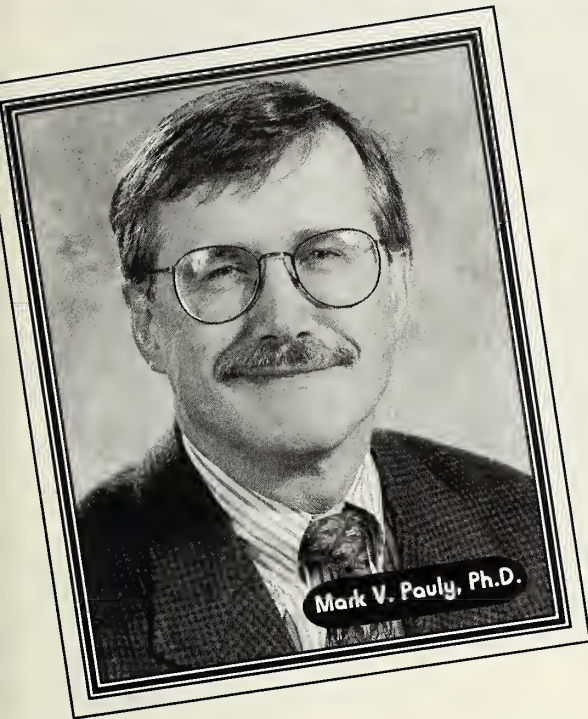
Arkansas Health Care  
Access Foundation, Inc.



# ARKANSAS MEDICAL SOCIETY 118TH ANNUAL SESSION



“THE BASES ARE LOADED . . .  
AMS’ AT BAT”



## **Statistics: Mark V. Pauly, Ph.D.**

Mark V. Pauly, Ph.D., will be the Shuffield Luncheon keynote speaker during the 118th AMS Annual Session on Friday, April 8, 1994 at 12:30 p.m. Dr. Pauly will address some misconceptions and hard realities surrounding the discussions of health care reform.

Dr. Pauly is one of the nation's leading health economists. He has analyzed Medicare and Medicaid financing, the impact of methods of paying health care providers on their behavior and the role of employment-related group insurance.

He is an active member of the Institute of Medicine, an adjunct scholar of the American Enterprise Institute and a member of the advisory board of the Washington-based Capital Economics.

He is Chairman and Professor of Health Care Systems Department and Professor of Insurance and Public Policy and Management at the Wharton School, and Professor of Economics in the School of Arts and Sciences at the University of Pennsylvania.

## **Shuffield Speaker: “The Challenges in Health Care Reform”**

**Mark V. Pauly, Ph.D.**

*-- Friday, April 8, 1994 12:30 p.m.*

## **Plus**

- \*CME Hours & Exhibits
- \*1994 AIDS Feature Session
- \*Inaugural Banquet
- \*Entertainment



## **Location**

- \*Excelsior Hotel & Statehouse  
Convention Center
- \*Little Rock, Arkansas
- \*April 7 - 9, 1994

# AMS Newsmakers

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**Dr. Sandra D. Bruce Nichols**, of Helena, was recently appointed director of the state Health Department by Gov. Jim Guy Tucker.

**Dr. Kelsey Caplinger, III**, of Little Rock was recently elected to the Board of Trustees of Ronald McDonald Children's Charities of Arkansas. A native of Fordyce, Caplinger is co-founder of the Little Rock Allergy Clinic, P.A. in Little Rock, and initiated Medical Camps of Arkansas, Inc. in 1971.

**Dr. Randall E. Cole** and **Dr. C. William Hof**, of Boozman-Hof Regional Eye Clinic in Rogers, recently participated in a national study with Alcon Surgical on the implantation of intraocular lens implants for cataract surgery.

**Dr. Ann Maners**, has been named chief of staff for CARTI. She is certified by the American Board of Radiology in Therapeutic Radiology and is a radiation oncologist at CARTI's Little Rock center. **Dr. Robert C. Landgren**, a radiation oncologist at CARTI, was named vice chief of the medical staff.

**Dr. Linda Martin**, a resident at UAMS, was recognized recently by the American Medical Association for her contributions to community service. She is one of 50 honorees of the AMA/Burroughs Wellcome Co. Leadership Award Program for resident physicians.

**Dr. Charles Rodgers**, of Little Rock, was recently reappointed to the Committee on Scientific Program of the American Academy of Family Physicians.

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## Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of December and January are:

James R. Adametz	Little Rock
Charles W. Craft	Greenwood
James Z. Mason	Little Rock
Kevin L. Pope	Fayetteville
Norman K. Pullman	Conway
Susan Raben	Springdale
Ronald N. Williams	Little Rock

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## In Memoriam

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### Jean C. Gladden, M.D.

Dr. Jean C. Gladden, of Harrison, died Wednesday, February 2, 1994. He was 75.

Survivors include his wife, Dee Gladden of Harrison; four children, King Gladden of Eureka Springs, Delphine Williams of St. Louis, Mo., Janie Corrigan of Fayetteville and Anne Milburn of Harrison; a sister, Vivien Magness of Harrison and eight grandchildren.

### William O. Green, III, M.D.

Dr. William O. Green, III, of Little Rock, died Monday, January 24, 1994. He was 39.

Survivors include his wife, Angie Smith Green; two sons, Will Green, IV, and Clint Green, both of Little Rock; a daughter, Olivia Green of Little Rock; his mother, Vernell Green of Blytheville; a brother, Dr. Phillip Green of Memphis; and three sisters, Terry Culp of Memphis and Annette Mosier and Yvette Thomas, both of Fort Smith.

### Joe Verser, M.D.

Dr. Joe Verser, of Harrisburg, died Thursday, February 3, 1994. He was 81.

Dr. Verser retired as secretary of the Medical Board in 1991, after serving for 45 years. He was also a past president of the Arkansas Medical Society and was senior delegate to the American Medical Association from 1969 to 1989. He was past president of the Mid-South Medical Assembly and was chief of staff in 1978-79 at Methodist Hospital of Jonesboro, where he was a member of the staff from 1977 until his death.

He is survived by his wife, Bobbie Linaker Verser; a son, Joe William Verser of Jonesboro; and a grandson.





# There's new hope for pain sufferers.



Exciting developments are taking place in the treatment of chronic and disabling pain. The Pain Care Center at Doctors Hospital in Little Rock is an interdisciplinary specialty unit designed to provide the most effective diagnostic and treatment services for:

Low back pain  
Post surgical pain

Myofascial pain syndrome  
Sympathetic maintained pain  
Other chronic pain syndromes

Migraine headache  
Work-related injuries

Patient referrals can be made by the attending physician simply by calling The Pain Care Center. All inquiries regarding our services are welcomed.

**The Pain Care Center at Doctors Hospital**  
**Doctors Building**  
**500 South University, Suite 707**  
**Little Rock, Arkansas 72205**  
**(501) 671-5505**

# Things To Come

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## **April 6-8**

**Temporomandibular Joint Update.** Silverado Resort, Napa, California. Sponsored by the UC Davis Medical Center, Office of CME. For more information, call (916) 734-5390.

## **April 8**

**Frontiers in Ovulation Induction.** Philadelphia, Pennsylvania. For more information, call the Office of Continuing Medical Education, Washington University School of Medicine, at (800) 325-9862.

## **April 15-17**

**44th Annual Postgraduate Symposium on Anesthesiology.** Ritz-Carlton Hotel, Kansas City, Missouri. For more information, call the University of Kansas Medical Center Office of Continuing Education, (913) 588-4490.

## **April 15-22**

**American Occupational Health Conference.** Hyatt Regency Chicago. Co-sponsored by the American College of Occupational and Environmental Medicine and American Association of Occupational Health Nurses. For more information, call Kay Coyne, (708) 228-6850.

## **April 16-22**

**79th Annual American Occupational Health Conference.** Hyatt Regency Chicago. For more information, call the American College of Occupational and Environmental Medicine, (708) 228-6850.

## **April 21-22**

**Prescription for the Future: What Way Health Reform? (a Managed Care Symposium).** Le Meridien Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call Office of CME, (504) 588-5466 or (800) 588-5300.

## **April 21-23**

**Pain and Pain Management.** Radisson Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call Office of CME, (504) 588-5466 or (800) 588-5300.

## **April 22-23**

**30th Annual Orthopaedic Symposium - Complications and Revisions of Total Hip and Total Knee Replacements.** The Omni Houston Hotel, Houston, Texas. Sponsored by St. Luke's Episcopal Hospital. Category I credit: 14 hours. For information, call Karin Thornton, (713) 791-4729.

## **April 27-28**

**State of the Art of Prevention of Heart Disease.** Westin Canal Place Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call Office of CME, (504) 588-5466 or (800) 588-5300.

## **April 28-30**

**Federation of State Medical Boards Annual Meeting.** Grand Hyatt, Washington, D.C. For more information, call George Washington University Medical Center, (202) 994-4285.

## **April 28-30**

**Primary Care Symposium III.** Hotel Intercontinental, New Orleans. Sponsored by the Hispanic/American Medical Association of Louisiana and the Tulane University Medical Center. For more information, call Office of CME, (504) 588-5466 or (800) 588-5300.

## **April 29**

**3rd Annual Pathology Forum.** UC Davis Medical Center, Cancer Center Auditorium, Sacramento, California. Sponsored by the Office of Continuing Medical Education. For more information, call (916) 734-5390.

## **April 29-30**

**Current Topics in Pathology IV: Hematopathology.** Westin Canal Place Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## **April 29-May 1**

**Pediatric Update for the Primary Care Physician.** Westin Canal Place Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## **April 30**

**Cancer in Women: Management of Breast and Gynecologic Malignancies for Health Practitioners Treating Women.** Cancer Center Auditorium, UC Davis Medical Center, San Francisco. For more information, call (916) 734-5390.

## **May 8-13**

**26th National Conference on Breast Cancer.** Marriott's Desert Springs Resort & Spa, Palm Desert, California. Sponsored by the American College of Radiology. For more information, call (800) 331-3112



### **May 12-14**

**Ambulatory Surgery '94: Healthcare Reform - Challenges and Opportunities.** Marriott Orlando World Center, Florida. Sponsored by the Federated Ambulatory Surgery Association. For more information, call (703) 836-8808.

### **May 13-14**

**Coming of Age: Geriatrics for the Primary Care Provider.** Sacramento Inn, Sacramento, Calif. Sponsored by Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

### **May 20-21**

**Functional Endoscopic Sinus Surgery.** Tulane School of Medicine, New Orleans. For more information, call the Office of CME at (504) 588-5466 or (800) 588-5300.

### **May 21**

**The Fifth Annual Rush Symposium on Transplantation.** Claude H. Searle Conference Center, Rush-Resbyterian-St. Luke's Medical Center, Chicago. For more information, call (312) 942-3114.

## **Attention all Medicaid Providers**

You are now eligible to defer up to 25% (up to \$7,500) of your Arkansas Medicaid receipts, saving tax dollars by reducing overall current taxable income.

We're aware of the severe time constraints on health professionals. Your VALIC representative, Britton Nowell, is ready to meet with you day or night, at your convenience.

For more information call  
1-800-44-VALIC (1-800-448-2542)  
or (501) 661-1146

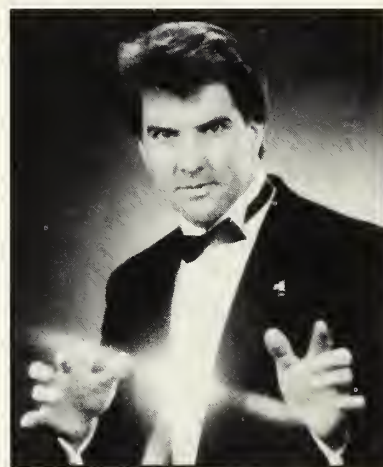
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# **The Power of Performance**

## **The Real Magic is in You!**

Experience the powerful performance by Andy L. Hickman as he skillfully entertains you with thrilling illusions at the AMS Inaugural Banquet on Saturday, April 9, 1993.

He will generate a fun-filled world of dazzling deceptions and dynamite showmanship that will levitate your attitude. Mark your calendar now... attend the 118th Annual Session in Little Rock.



**Andy L. Hickman  
Dallas, Texas**

**The Bases are Loaded . . . AMS' at Bat**  
**118th Annual Session** **April 7 - 9, 1993**  
**Excelsior Hotel/Statehouse Convention Center**  
**Little Rock, Arkansas**

# Keeping Up

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## **1994 Infectious Diseases Update**

March 18 & 19, 8:00 a.m., Lake Hamilton Resort, Hot Springs. Sponsored by Arkansas Children's Hospital and presented by Richard Jacobs, M.D. Fee: \$125; Category I credit: 8 hours.

## **Symposium on Critical Care and Emergency Medicine**

April 7-9, 8:15 a.m., Arlington Hotel and Resort Spa, Hot Springs. Sponsored by UAMS College of Medicine and presented by Terry Yamauchi, M.D. & Milton Deneke, M.D. Fee: \$200.

## **Management of Dementias in the Elderly**

April 13, time to be announced, Excelsior Hotel, Little Rock. Sponsored by UAMS College of Medicine and presented by David A. Lipschitz, M.D. and Ronnie Chernoff, Ph.D. Fee: approximately \$100.

## **Advances in the Diagnosis and Management of Breast Cancer**

April 14-16, 7:30 a.m., registration and continental breakfast, Statehouse Conference Center, Little Rock. Sponsored by UAMS and the American Cancer Society. Presented by Suzanne Klimberg, M.D. Category I credit: 13.5 hours. Fee: \$300 for physicians. For more information, call 686-6503.

## **Arkansas Perinatal Association**

April 18, time and location to be announced. Sponsored by UAMS College of Medicine and presented by Russell Kirby, M.D.

## **Advances in Cardiology**

April 19, 6:30 p.m., Baxter County Regional Hospital Education Building, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Paul Freiman, M.D. No fee; Category I credit: 2.0 hours.

## **W.W. Stead Chest Symposium**

April 23, time to be announced, Holiday Inn-City Center, I-630 & Broadway, Little Rock. Sponsored by UAMS College of Medicine and presented by Marcia Erbland, M.D.

## **Diabetes Update**

May 7, Registration 8:00 a.m., Hilton Inn, Little Rock. Sponsored by University of Arkansas for Medical Sciences and presented by Vivian Fonseca, M.D.

## **Deep Vein Thrombosis and Pulmonary Embolism**

May 17, 6:30 p.m., Baxter County Regional Hospital Education Building, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Robert Lavender, M.D. No fee; Category I credit: 2.0 hours.

## **Sixteenth Annual Family Practice Intensive Review**

June 3-5, time to be announced, UAMS, Little Rock. Sponsored by UAMS and presented by Jerry Mann, M.D. and Mary Lindsey, L.C.S.W.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **FAYETTEVILLE-VA MEDICAL CENTER**

General Medical Topics, Thursdays, 12:00 noon, Auditorium, Bldg. 3

Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

Continuing Medical Education Luncheon, Mar. 25, Apr. 8 & 22, May 13 & 27, 12:30 p.m., AMI Ozark - Quapaw Room

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium

Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457

Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom



*Pediatric Grand Rounds*, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
*Pediatric Neuroscience Conference*, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
*Pediatric Pharmacology Conference*, 5th Wednesday, 12:00 noon, 2nd Classroom  
*Pediatric Research Conference*, 1st Thursday, 12:00 noon, 2nd Floor Classroom

#### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Cancer Conferences*, Thursdays, 12:00 noon, location to be announced. Lunch provided.  
*Chest Conference*, 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon, CARTI Auditorium. Lunch provided.  
*Journal Club*, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Mental Health Conference*, 3rd Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided.

#### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*Breast Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*GI Conference*, 4th Friday, 11:30 a.m., Conference Room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

#### **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Chest & Problems Case Conference*, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Medicine Conference*, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Surgery Conference*, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*X-ray Case Conference*, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

#### **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B

*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS Jones Eye Institute, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Jones Eye Institute  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GRECC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

## EL DORADO-AHEC

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas



## **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center*  
*AHEC Teaching Conferences, Fridays, 12:00 noon, Washington Regional Medical Center*  
*AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center*  
*Medical/Surgical Conference Series, 4th Tuesday, 12:30, Bates Medical Center, Bentonville*  
*Primary Care Conferences, 1st & 3rd Mondays, 12:00, every Tuesday 7:30 a.m., Washington Regional Medical Center*

## **FORT SMITH-AHEC**

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*Osteoporosis, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith*  
*Sparks Tumor Conference, Thursdays, 12:00 noon, Sparks Regional Medical Center*  
*Tumor Conference, Mondays, 12:00 noon, St. Edward Mercy Medical Center*

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.*  
*Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould*  
*Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.*  
*Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn*  
*Clinical Faculty Conference, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided*  
*Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club*  
*Harris Hospital Tumor Conference, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room*  
*Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville*  
*Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.*  
*Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport*  
*Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO*  
*Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro*  
*Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.*  
*Orthopedic Case Conference, every other month beginning April 28, 7:30 a.m.*  
*Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.*  
*Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom*  
*Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.*  
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*Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center*  
*Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center*  
*Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center*  
*Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.*  
*Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center*  
*Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center*  
*Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.*  
*Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center*  
*Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center*

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*Chest Conference, every other 3rd Wednesday, 12:30 p.m., St. Michael Hospital*  
*Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center*  
*Residency Noon Conference, Tuesdays, Wednesdays and Thursdays, 12:30 p.m., AHEC-Southwest Family Practice Clinic*  
*Tumor Board, Fridays, except 5th Friday, 12:00 noon, Wadley Regional Medical Center & St. Michael Hospital*  
*Tumor Conference, every 5th Friday, 12:00 noon alternates between Wadley Regional Medical Center & St. Michael Hospital*



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# Continuing Medical Education The Quiet Revolution

Lee Lee Doyle, Ph.D.\*

As the debate over undergraduate medical school education rages on in professional and lay journals, a little noticed or reported revolution is occurring in the field of continuing medical education (CME). The seeds may have been sown when the American Medical Association (AMA) decreed that a certain percentage of the credit hours necessary to earn the Physician's Recognition Award (PRA) could be from Category 2. This category allows the individual physician to be involved in choosing educational methods and opportunities suited to her/his individual needs. Unlike Category 1 credits which must be designated, recorded and reported by a sponsor accredited by the Accreditation Council for Continuing Medical Education (ACCME), the individual physician recorded and reported these credits to the AMA. Conferences, rounds, journal reading, listening to educational tapes, all were considered valuable educational experiences even though they might not meet all the formal criteria for Category 1 credits. The AMA recognized that physicians had a right and a responsibility in determining how to best meet their own individual needs for continuing education. The designation of the credit for this type of education as Category 2 was unfortunate since although the AMA considered it of equal value and importance to Category 1, most physicians tended to discount these "second class" opportunities for education and consider them inferior to Category 1 credits.

Last year, perhaps in an attempt to alter this misperception, the AMA published new guidelines for the PRA that made a certain percentage of Category 2 credits mandatory. The message was clear; self directed learning (SDL) is an important part of any physician's continuing medical education. At a recent meeting of the Alliance for Continuing Medical Education (ACME),

SDL was a hot topic, discussed in several workshops as well as during formal plenary sessions. One of the newest trends in CME is to lessen the emphasis on formal multi-day meeting and start working with individual physicians to help them determine their own educational needs, decide how they want to meet them, identify the resources available and how to obtain them, and how to evaluate whether they succeeded or not.

Why is SDL suddenly receiving all this attention? For many years, educational research has demonstrated that acquisition and retention are both improved when the learner is an active participant in the learning process. Additionally, individuals have preferred styles of learning. Visual learners like books, auditory learners prefer lectures and kinesthetic learners want movement and "hands-on" experiences. SDL takes both these findings into account. With increasing demands on physicians' time, it is important that CME providers help physicians spend it most effectively.

How does SDL work? In the past, a physician knew he/she had to have a certain number of CME credits to meet the requirements of state, hospital or specialty board. In order to obtain such credits he/she would attend formal meeting (hopefully in scenic surroundings) leaving a busy practice to spend seemingly endless hours in an audiovisual twilight listening to a series of talking heads. Minimal time was allotted for questions and answers with the experts and even less devoted to professional exchange between colleagues. Generally there were a few topics that were relevant to each physician, but much of the subject matter was of little interest or good to the individual physician. The fact that the physician might not be particularly good at auditory learning was never even considered.

In the new paradigm for CME, the physician calls the CME office and works with a CME professional who will function as both a consultant and broker. The physician will outline what he wants to learn and the CME specialist will work with the physician to set up

\* Lee Lee Doyle, Ph.D., is Associate Dean for Continuing Medical Education and Faculty Development, University of Arkansas for Continuing Medical Sciences.

clearly stated learning objectives. Together they will identify the preferred learning style of the physician and then choose what kinds of material will be most effective; taped lectures, video tapes, rounds, books, computer assisted instruction (CAI), selected journal articles or some combination of the above. As a team they will set up an educational plan for the physician and determine the best method to evaluate when and if the physician's needs have been met. The CME specialist acts as the broker for other services provided by others such as a medical librarian who can assist in preparing a bibliography or a media expert who can identify available tapes and arrange for the physician to get the necessary materials. In some cases, such as CAI, learning how to use the resources will be part of the overall plan.

At UAMS the CME office is interested in and exploring how to provide SDL for physicians in Arkansas. Initially, as both physician and CME specialist learn to work in this new, individualized environment, the up-front preparation time may seem large and costly, but the focused education should decrease the overall time by the physician in continuing education, increase the cost effectiveness and result in satisfaction by both parties in a job done efficiently and effectively. ■



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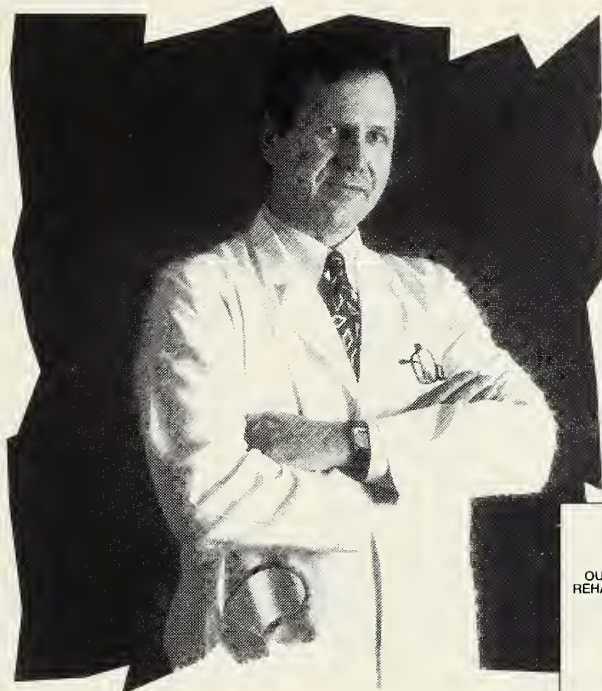
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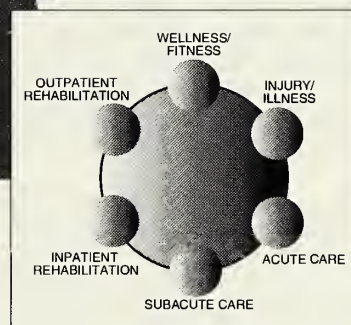


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# The Arkansas Cancer Pain Initiative

A. Reed Thompson, M.D., Chairman\*

Healthcare providers who deal regularly with cancer have formed a statewide organization called "The Arkansas Cancer Pain Initiative" to address the problem of cancer pain in Arkansas. It is clear from the medical literature in this country that cancer pain problems are not optimally addressed by caregivers.<sup>1</sup> The failure to adequately address cancer pain is not caused by lack of availability of pharmacologic agents, or lack of available technology, or by a lack of concern of health care professionals. It is caused by barriers that exist in healthcare delivery.<sup>3</sup> The two most important ones are:

- **Pain management is not a high priority with physicians.**

This is not to say that physicians are not concerned about their patients' pain, but controlling disease takes precedence over symptom control. By controlling diseases, symptoms from the disease can be eradicated or improved significantly. It is the patients in which this does not happen, and who continue to receive aggressive therapies at the expense of symptom management, that are addressed by the Pain Initiative.

- **A cultural bias exists in this country concerning the use of opioid drugs.**

This bias adversely affects healthcare provider and consumer attitudes. The "war" on drugs has been most effective in increasing the awareness of Americans toward the dangers of using opioid analgesic drugs. It has indeed been so effective that many patients, who would benefit from opioid analgesics, do not use them, either because the drugs are

not prescribed, not dispensed as ordered, or not taken as directed. The restrictions on prescribing and dispensing Schedule II controlled drugs placed by state and federal regulator agencies to prevent illicit trafficking in prescription drugs contribute to the reluctance of physicians in writing and pharmacists in filing prescriptions for opioid analgesics. This is not to say the drugs should not be controlled, but excessive regulation may prevent delivery of the drugs to those patients truly in need.

## MISSION

The mission of the Arkansas Cancer Pain Initiative is to be an agent of change in the management of cancer pain, primarily through addressing the barriers that obstruct proper pain management. This is done through statewide educational efforts that intend to reach physicians, nurses, pharmacists, social workers, regulators and consumers.

## DEFINITION

The definition of a cancer pain initiative is that it is an interdisciplinary coalition which aims to improve pain management in cancer patients through education. The State Cancer Pain Initiative program is a World Health Organization project.<sup>4</sup> The pilot project is in Wisconsin, which began in 1986. There are now over 30 states in the United States that have cancer pain initiatives (see figure 1).

The cancer unit of the World Health Organization, has as one of its priorities, pain and symptom management in patients with cancer, worldwide. In the developing countries sophisticated medical technologies are frequently not available, and survival rates are abysmal. In response to this, the World Health Organization is promoting pain and symptom control in cancer patients in these countries rather than medical interventions aimed at disease control. A different strategy is underway in the developed countries. The method

\* A. Reed Thompson, M.D., is Chairman of the Arkansas Cancer Pain Initiative and Assistant Professor, Department of Otolaryngology-Head and Neck Surgery, University of Arkansas for Medical Sciences.



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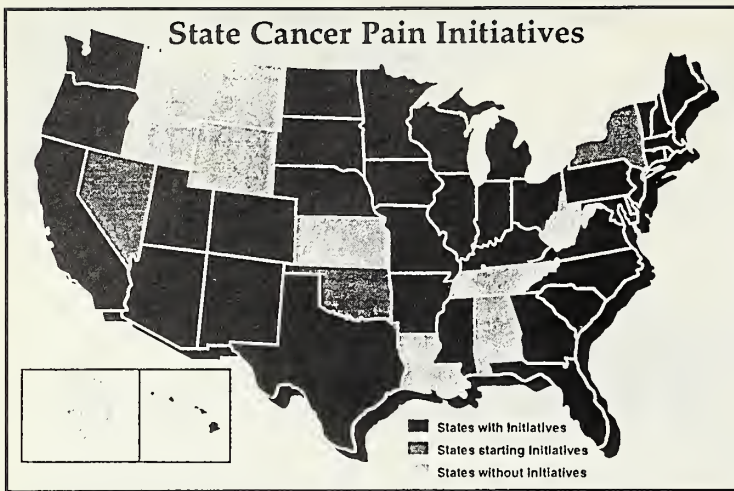
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chosen to promote symptom management in the United States is the cancer pain initiative program.

## GOALS

The goals of the Arkansas Cancer Pain Initiative are as follows:

1. Make the relief of cancer pain a high priority in the healthcare system in Arkansas.
2. Make pain relief an expectation in all cancer patients in Arkansas.

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3. Dispel the myths of opioid drugs.
4. Educate healthcare providers and consumers regarding drug and non-drug therapies for cancer pain relief.

## SCOPE OF THE PROBLEM

Just how much of a problem is cancer pain in Arkansas? The American Cancer Society recorded 12,600 new cancer patients in Arkansas in 1992, and a projected 13,200 new cancer cases will be diagnosed in 1993.<sup>2</sup> It is estimated that there are 40,000 people alive with cancer in Arkansas. Seventy to eighty percent of those have pain during their illness.<sup>1</sup> About one in three Arkansans will develop cancer in their lifetime,<sup>2</sup> and three out of four families will be touched by cancer.

## SUMMARY AND PLAN OF ACTION

The Arkansas Cancer Pain Initiative is an interdisciplinary coalition aiming to improve pain management in cancer patients through education of healthcare providers and consumers. Each state initiative develops its own organizational structure and its own methods for disseminating information. Conferences on pain management are sponsored, newsletters are distributed to interested parties, and interdisciplinary groups develop educational programs designed to be delivered in the communities throughout Arkansas. The general organizational structure calls for a chairman and co-chairman, a paid part time project coordinator and several standing committees. It is an all volunteer organization, except for the paid part time project coordinator. The committees are made up of physicians, nurses, social workers, psychologists, controlled substance regulators and individuals interested in publicity/public relations.

The Arkansas Cancer Pain Initiative has only recently been organized. More interested parties are needed to volunteer their time to help the organization disseminate its message. Interested parties are encouraged to contact:

Jonathan J. Wolfe, Ph.D.

College of Pharmacy

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### Hospitals

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- Capital spending funds
- Endowments
- Foundations
- Funded depreciation or asset renewal pools
- Pensions and other retirement plans
- Self insurance funds
- Short-term operating funds
- Investment of proceeds from bond issue

Since these segmented funds have distinct goals, they should have separate guidelines and investment strategies. Each fund will require different management techniques. For example, The funded depreciation pool may be invested in fixed-income investments, while your operating funds require short-term instruments. Your pension plans may consider the social aspects of potential investments as well as projected returns, while your capital spending funds may not. Regardless of the fund's objectives, caps on reimbursement from Medicaid and other insurance programs combined with a dramatic declines in interest rates have increased the pressure to maximize the returns earned. The return on the investments in these funds will determine how much money your hospital will be able to spend on new products and services. Ultimately, the returns earned on these funds will effect the long-term financial health of your hospital.

### Increasing Returns

Is your hospital receiving the best returns possible within the risk limits appropriate for each fund's objectives? Can those returns be increased without violating your risk constraints? The initial step in increas-

ing the returns of your hospital's funds should be to develop an investment policy statement and guidelines for each fund. Existing policy statements and guidelines should be reviewed.

The investment policy statement is a broad outline of the fund's structure. The policy statement should include the following considerations:

1. The purpose of the fund
2. Broad investment policy
3. Goals and objectives
4. Make-up of the Finance/Investment Committee, frequency of meetings, responsibilities

The investment guidelines outline more specific details of the ways in which your funds are invested. The guidelines should include the following:

1. Fund objectives
2. Maximum maturity of any fixed income investments in the fund
3. Liquidity of holdings
4. Eligible investments
5. Frequency and level of communications with the investment manager
6. Credit quality
7. Marketability of holdings
8. Reporting requirements
9. Reinvestment of principal and interest
10. Limits on concentration of holdings
11. Discretionary authority to investment manager
12. Diversification standards

After a review of policy and guidelines, and any necessary revisions, an appraisal of each fund's performance should be undertaken. If you are using an independent investment manager, your appraisal of the manager should include:



<b>Service</b>	Are you receiving timely reports and clear communications?
<b>Defensive</b>	Does your manager give you good down-side protection?
<b>Understanding</b>	Does your manager understand the objectives of each fund?
<b>Performance</b>	How does your manager's performance compare to other managers with similar styles? Most importantly, is the performance satisfactory relative to your goals and objectives?
<b>Compliance</b>	Does your manager comply with the funds' investment policy and guidelines?

## Asset Allocation

Reviewing your funds' asset allocation is the next step in increasing your returns. An asset allocation study should include consideration of extending maturities of the fixed income investments and broadening the eligible investment vehicles.

## Professional Management

Due to increased size and complexity, in-house management of your hospital's funds may be impractical. Yet locating an appropriate investment manager

can be a difficult task. Investment Management Consulting Services can help your hospital identify, select and monitor an asset manager. Consulting services should include:

- Review of investment policy statements and investment guidelines. Updating and development as necessary.
- Review of each fund's performance.
- Review of investment managers to meet standards for assets under management, experience, research capabilities, legal standing, performance and investment style.
- Screening to present your hospital with suitable candidates.
- Extensive profiles and performance histories of each candidate.
- Ongoing performance monitoring relative to your funds' objectives.

A professional investment management consultant can work with your hospital to accomplish the steps outlined in this article.

---

*Jim Coffield and Todd Smurl are Financial Advisors with the Little Rock office of Prudential Securities Incorporated. Any opinions expressed in this article are those of the authors, and not those of Prudential Securities.*

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Patricia Burge, M.S., C.I.H.\*

Stan Evans, B.S., R.S.\*\*

During the past two years, considerable attention has been focused on the issue of mercury toxicity. This started after testing revealed that, in some instances, mercury levels in fish taken from certain waters in Arkansas exceeded the FDA guidelines of 1 part per million (ppm). The waters initially impacted were the lower Saline and Ouachita rivers in an eight-county region in Southern Arkansas which included Ashley, Bradley, Calhoun, Cleveland, Dallas, Drew, Ouachita and Union counties. Additional testing has revealed that fish in other bodies of water in the state also exceed 1 ppm mercury. The Arkansas Department of Health responded to these findings by issuing a series of fish consumption advisories beginning in September, 1992. The intent of these advisories was to inform the fish-consuming public: 1) that mercury levels in fish taken from identified waters exceeded the FDA guidelines, and 2) to provide some guidance on safe consumption patterns and amounts.

In 1992, as a result of general public concerns, \$5,000 was released from the Governor's Emergency Fund to provide blood mercury screenings for individuals living in the eight-county area originally impacted by the fish consumption advisories. This screening was provided as a service to the public. Although the information that was obtained is of interest, it is not appropriate to extrapolate the findings to other population bases or situations since:

- Control groups were not used;
- Blood for the screening was drawn approximately four months after the first advisory (if participants altered their normal fish consumption patterns when the advisory was first issued, the approximately 60-day half-life of mercury in the blood would have permitted a

significant drop by the time the blood was drawn);

- Provisions were not made for systematic or random selection of the individuals;
- Fish consumption was self-reported based on recall;
- The study group, which was entirely voluntary, included few women and children.

In order to qualify for the screening program, potential participants were required to confirm that their consumption rate was a minimum of two meals per month (eight ounces of fish per meal) of fish taken from the affected waters. The funding enabled the Department of Health to provide a total of 236 blood mercury screening tests. A summary of the findings is provided in Table 1. Again, it should be emphasized that this information is provided for general interest and should not be used to estimate exposures to other populations or situations.

Since mercury is ubiquitous in nature, most individuals have some degree of mercury body burden. This level varies based on factors such as occupation and fish consumption. This body burden may develop as a result of exposures to elemental, inorganic or organic mercury compounds. For most individuals, fish consumption is the single largest source of mercury exposure.<sup>1</sup> The Agency for Toxic Substances Disease Registry estimates that approximately 70 to 90% of the mercury in contaminated fish is an organic form, primarily monomethyl mercury.<sup>1</sup> A more recent study indicates that this number may actually be as high as 95%.<sup>3</sup> Therefore, barring occupational or other significant sources of exposure, monomethyl mercury is usually assumed to be the form of mercury in the human body burden. This is of importance since the different forms of mercury exhibit slight differences in target organ effects, solubility and binding factors and the levels at which adverse effects may occur. Blood mercury levels of up to 20 ppb are generally considered to be acceptable.

For elemental and inorganic mercury, the nervous

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system and kidneys appear to be the sensitive target organs. In the case of most organic mercury compounds, the kidney does not appear to be as sensitive as the nervous system. However, the developing nervous system is a particular risk to the adverse effects of many organic mercury compounds. Monomethyl mercury is fat soluble, but bonds readily and strongly to protein; it readily crosses both the blood-brain and placental barriers. Monomethyl mercury also attaches to the proteins in milk and thus may be passed from a nursing mother to her infant in significant amounts.

In adults, the symptoms of overexposure to monomethyl mercury are manifested primarily in the

vous system. In one of the poisoning epidemics, mental retardation and cerebral palsy-like symptoms were seen among some of the children born to asymptotic mothers.<sup>2</sup> These effects are often delayed, in some cases not appearing until the children were approximately two years of age. The primary toxic mechanism of organic mercury compounds results in damage to the central nervous system. This damage includes degeneration and necrosis of neurons in focal areas of the cerebral cortex, particularly in the visual areas of the occipital cortex and in the granular layer of the cerebellum.<sup>2</sup> Additionally, probably due to the affinity of organic mercury compounds for erythrocytes (approximately 90% of the monomethyl mercury present in the human body is bound to erythrocytes), total blood mercury in newborns is typically four to ten times higher than in their mothers.<sup>2</sup>

The significance of blood mercury levels between 20 ppb (generally recognized as safe) and 200 ppb (LOAEL for adults) is difficult to interpret at this time. The fish consumption advisories established by the Health Department were designed to maintain blood mercury levels at 20 ppb or below. Sensitive populations (pregnant women, women planning on becoming pregnant, breast-feeding women and children under age seven) are encouraged to not consume fish which may contain 1 ppm of mercury or more. The advi-

central nervous system. Especially in the early stages of intoxication, these symptoms may be very nonspecific, including such diverse sequela as paresthesia, memory loss, learning difficulties, ataxia, dysarthria, emotional disturbances, vision and hearing disturbances, spastic and jerky movements, and dizziness. Other symptoms usually associated with more acute poisoning include salivation, lacrimation, nausea, vomiting, spastic and jerky movements, diarrhea and constipation. The lowest observable adverse effect level (LOAEL) for symptoms of mercury intoxication in adults is usually taken to be 200 parts per billion (ppb) total mercury in whole blood.<sup>1</sup> However, in recent times, two outbreaks of severe accidental exposure to organic mercury compounds - primarily through ingestion of contaminated foods - have shown that fetuses and children under age seven are at particular risk due to specific damage which may occur to the developing ner-

sories provide guidance for individuals in the non-sensitive populations so that consumption of fish containing 1.0 to 1.5 ppm mercury can continue in moderation. It is recommended that fish containing more than 1.5 ppm mercury not be consumed by any segment of the population.

At this time, no overt cases of mercury poisoning as a result of eating fish taken from Arkansas waters have been reported. The highest whole blood mercury level found in the screening project was 75 ppb, a level still well below the 200 ppb LOAEL point at which paresthesia, visual impairment and other CNS effects begin to be noted. Because chronic symptoms of mercury poisoning (i.e., memory loss, learning difficulties, impaired vision and occasional tremors) may be associated with other neurological diseases as well as changes typically associated with aging, physicians should inquire as to fish consumption patterns from

Table 1

Blood Mercury Screening

Category	Range	Mean	Median	N
All Data	0-75 ppb	10.5 ppb	7.1 ppb	236
Males	0-75 ppb	12.8 ppb	9.0 ppb	143
Females	0-26.6 ppb	6.9 ppb	4.8 ppb	93

Other points of interest:

1. 139 participants exceeded 5 ppb.
2. 36 participants were in the range of 20 to 75 ppb.
3. 25% were below the limit of detection (2 ppb).
4. 15% were above 20 ppb.
5. 7% of the females had levels greater than 20 ppb.
6. 20% of the males had levels greater than 20 ppb.
7. 5% of the males had levels greater than 30 ppb.
8. No females had levels greater than 30 ppb.

waters included in the fish consumption advisories. If indicated, blood mercury levels should be determined. A heparinized blood sample should be drawn and submitted to an appropriate laboratory for analysis. The Arkansas Department of Health has obtained funding to purchase equipment for the analysis of mercury in blood. The Department plans to use this equipment to provide additional screening for blood mercury levels in the impacted areas. The service will be targeted towards high risk groups, such as pregnant women being served by maternity clinics in the local health units and young children in the EPSDT clinics. Blood mercury testing is also available from some commercial laboratories. Hair may also be analyzed for mercury. However, this matrix often is contaminated with mercury from other sources which do not reflect the mercury body burden and is usually used only when a historical exposure history is desired.

As previously indicated, if the blood mercury level is found to be 20 ppb or less, mercury poisoning at the current time would not be a factor. However, if fish consumption patterns have been significantly reduced, it should be recognized that the blood mercury level may have peaked at a level higher than that indicated by the test results. Test results of 200 ppb or more would be sufficient evidence to diagnose mercury poisoning. In these instances, the patient should be advised to discontinue consumption of fish taken from the waters under advisement until their blood mercury levels falls to 20 ppb or less. The 60-day half-life of mercury in blood can be used to estimate when fish consumption could safely resume. In any instance, patients should be encouraged to observe the Fish Consumption Advisories which are issued by the Arkansas Department of Health.

There are no current recommended medical interventions for mercury intoxication other than support and removal from exposure. The latter utilizes the approximate 60-day half-life of mercury in blood to estimate the length of time exposure must be eliminated in order to reduce blood mercury to a safe level. For example, one individual who participated in the blood screening program abstained from consumption of fish taken from the affected waters for approximately sixty days and reduced his blood mercury from 29 ppb to 12.5 ppb.

Sampling and testing of the fish in Arkansas' waters is continuing. Updates of the fish consumption advisories are periodically published to reflect additional information that has been collected. At the present time, efforts are focused on defining precisely the bodies of water, species of fish, and sizes of fish which are likely to exceed the FDA 1 ppm limit. As new advisories are issued, they will be available through local recreational fishing industries (bait & tackle stores, businesses selling fishing licenses, etc.), the local Game and

Fish representative and the Department of Health's Local Health Units. Research efforts are also focused on determining the source(s) of mercury contamination in Arkansas.

Additional information regarding the mercury in fish situation may be obtained by contacting Mr. Stan Evans or Ms. Patricia Burge, Office of Epidemiology, Arkansas Department of Health, (501) 661-2893.

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2. Klaassen CD, Amdur MO, Doull J. Casarett and Doull's Toxicology, 3rd edition, Macmillan Publishing Company, New York, 1986.
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OF SEASONAL  
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- **Rapid-acting†**

CLARITIN Tablets started working in some patients in as soon as 30 minutes; 65% of patients experienced relief within 2 hours.†

- **Once-a-day dosing**

- **Low incidence of adverse effects**

In controlled clinical trials using the recommended dose, the incidence of headache (12%), somnolence (8%), fatigue (4%), and dry mouth (3%) with CLARITIN Tablets was similar to that of placebo (11%, 6%, 3%, and 2%, respectively).

- **Over 1 billion patient days of worldwide experience**

**Clear Benefits  
From Start To Finish**

**Once-a-day**

**Claritin**  
10 mg (loratadine)  
TABLETS

\* In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed.

† Relief began in 13% of treated patients vs 4% of placebo-treated patients within 30 minutes (P=0.04). At 2 hours, 48% of patients receiving placebo experienced relief. Distribution of onset times was significantly earlier for CLARITIN Tablets vs placebo (P=0.03).

Please see following page for brief summary of Prescribing Information.



**CLARITIN®**  
brand of loratadine  
**TABLET**  
Long-Acting Antihistamine  
**BRIEF SUMMARY**  
(For full Prescribing Information, see package insert.)  
**INDICATIONS AND USAGE**  
CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

**CONTRAINDICATIONS**  
CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

**PRECAUTIONS**  
**General:** Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

**Drug Interactions:** The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

**Carcinogenesis, Mutagenesis, and Impairment of Fertility:** In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in vitro (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

**Pregnancy Category B:** There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

**Nursing Mothers:** Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC<sub>0-12</sub>/AUC<sub>0-12</sub> ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

**Pediatric Use:** Safety and effectiveness in children below the age of 12 years have not been established.

**ADVERSE REACTIONS**  
Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN  
PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS  
PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients.

**Autonomic Nervous System:** Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing, Body As A Whole: Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.

**Cardiovascular System:** Hypotension, hypertension, palpitations, syncope, tachycardia.  
**Central and Peripheral Nervous System:** Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.

**Gastrointestinal System:** Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.

**Musculoskeletal System:** Arthralgia, myalgia.

**Psychiatric:** Anxiety, depression, agitation, insomnia, parosmia, amnesia, impaired concentration, confusion, decreased libido, nervousness.

**Reproductive System:** Breast pain, menorrhagia, dysmenorrhea, vaginitis.

**Respiratory System:** Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.

**Skin and Appendages:** Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.

**Urinary System:** Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema, abnormal hepatic function, including jaundice, hepatitis, and hepatic necrosis; alopecia; seizures; breast enlargement; erythema multiforme; and anaphylaxis.

#### OVERDOSAGE

Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdose, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdose would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD<sub>50</sub> values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

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*Clin Ther.* 1992;14:268-275.

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Volume 90, Number 11 - April 1994

# YOCON®

## YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

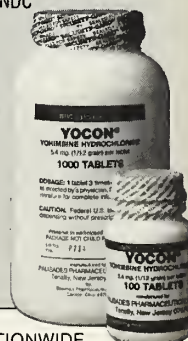
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

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Her naked skin, bronzed against the blue sea  
Water drops scattered by the blowing winds,  
On the dry torrid sands, making a circle around her body.  
She stood still, a prisoner of her own thoughts.

The beach was deserted except for her,  
Pink towel and the white bikini;  
The top, left cup crumpled in the sand  
The right, taut against wet beach  
Bottom fallen about one hundred feet away,  
And in between her hurried foot prints,  
Perhaps counting the sands of time.  
A free spirit drifting in the mist.

A beautiful body trampled by the surgical knife,  
Bones full of horrid material and aching pain.  
The nausea of radiation and chemotherapy,  
Made her senses numb.

She stood still, like a ghost in church,  
of Bygone memories and  
sinless silhouette of a remorseful Nun.  
A free spirit drifting in the mist.

Shyam P. Mehta, M.D.  
Pine Bluff



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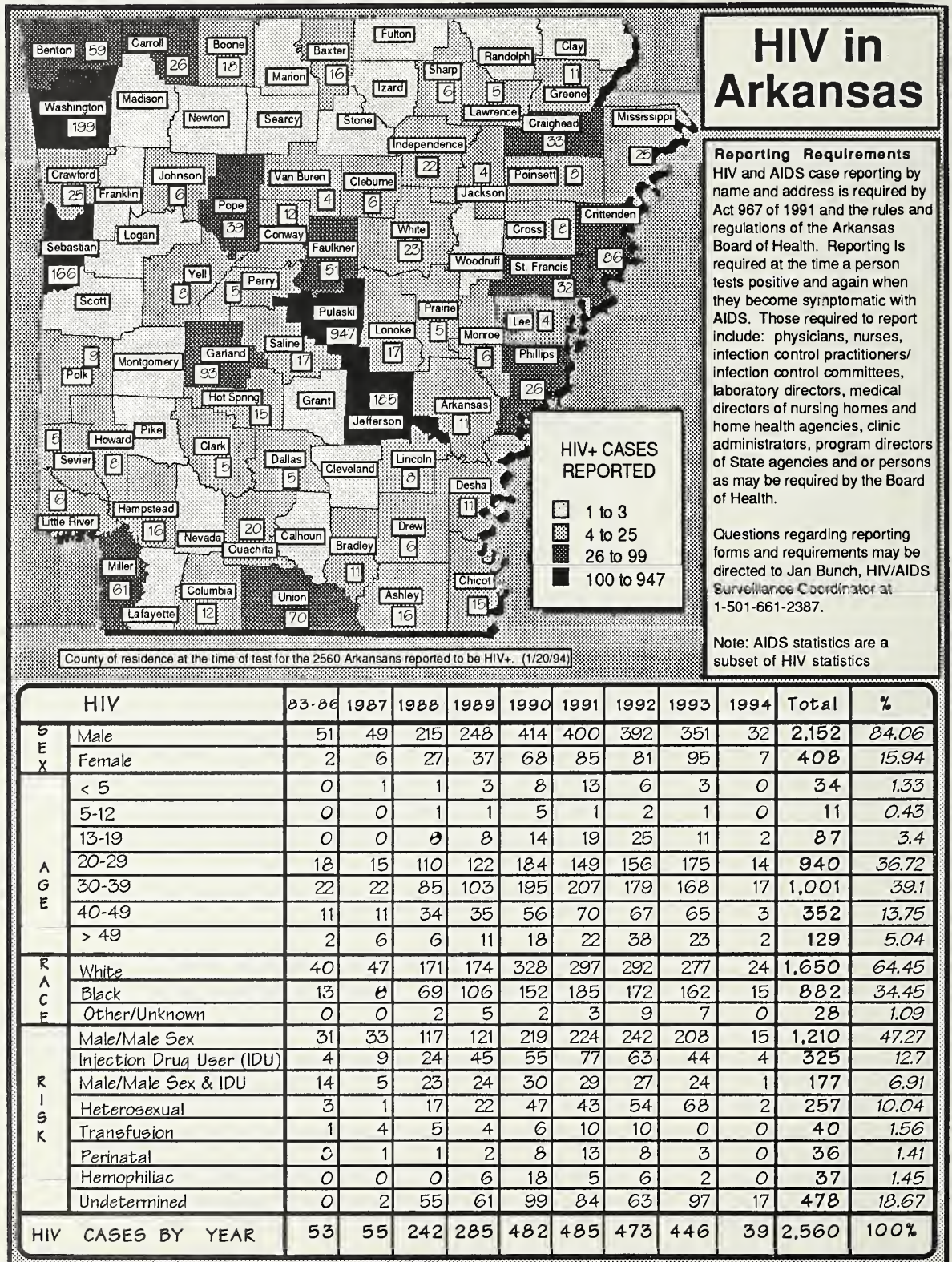
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Arkansas Health Care  
Access Foundation, Inc.



# Arkansas HIV/AIDS Report 1983-1994



Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1994

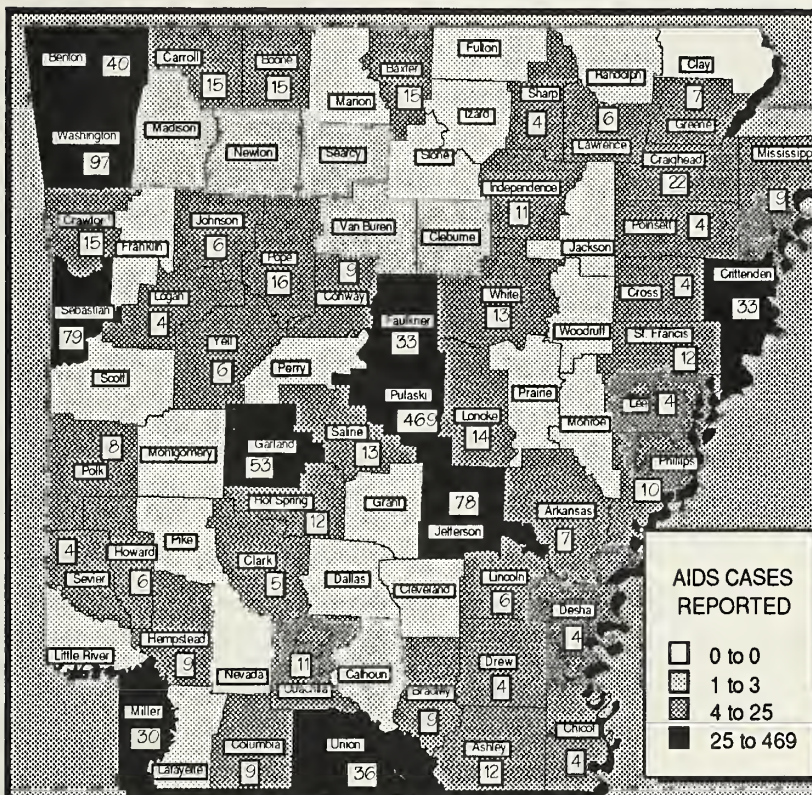
### AIDS in Arkansas

#### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Act 967 of 1991 and the rules and regulations of the Arkansas Board of Health. Reporting is required at the time a person tests positive and again when they become symptomatic with AIDS. Those required to report include: physicians, nurses, infection control practitioners/infection control committees, laboratory directors, medical directors of nursing homes and home health agencies, clinic administrators, program directors of State agencies and or persons as may be required by the Board of Health.

Questions regarding reporting forms and requirements may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator at 1-501-661-2387.

Note: AIDS statistics are a subset of HIV statistics



Of the 2560 Arkansans reported to be HIV+, 1352 have been diagnosed with AIDS. (1/20/94)

AIDS		83-86	987	1988	1989	1990	1991	1992	1993	1994	Total	%
SEX	Male	39	46	77	70	170	176	250	335	22	1,185	87.65
	Female	1	4	6	10	20	25	35	65	1	167	12.35
AGE	< 5	0	0	1	1	6	6	3	2	0	19	1.41
	5-12	0	0	1	0	1	1	0	1	0	4	0.3
	13-19	0	0	0	0	4	3	2	4	0	13	0.96
	20-29	16	15	27	24	55	57	81	110	2	387	28.62
	30-39	16	23	36	41	78	80	128	178	13	593	43.86
	40-49	7	8	10	7	35	41	52	78	5	243	17.97
	> 49	1	4	8	7	11	13	19	27	3	93	6.88
RACE	White	31	43	61	58	141	134	206	275	16	965	71.38
	Black	9	7	20	21	47	66	75	121	7	373	27.59
	Other/Unknown	0	0	2	1	2	1	4	4	0	14	1.04
RISK	Male/Male Sex	24	31	59	50	120	120	179	215	17	815	60.28
	Injection Drug User (IDU)	2	10	4	11	18	29	43	57	4	178	13.17
	Male/Male Sex & IDU	12	4	6	6	18	17	19	24	1	107	7.91
	Heterosexual	2	2	3	6	10	9	25	45	0	102	7.54
	Transfusion	0	2	7	3	7	11	3	2	0	35	2.59
	Perinatal	0	0	1	1	6	6	3	3	0	20	1.48
	Hemophiliac	0	0	1	1	5	5	4	5	0	21	1.55
	Undetermined	0	1	2	2	6	4	9	49	1	74	5.47
AIDS CASES BY YEAR		40	50	83	80	190	201	285	400	23	1,352	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# New Members

---

## BATESVILLE

**Bates, Ronald J.**, Family Medicine. Medical education, UHSCOM, Kansas City, Missouri, 1989. Internship, Tulsa Regional Med Center, 1990. Residency, OSU/COM, 1992. Board certified.

**Bosch, Charles W.**, Enterology. Medical education, University of Health Sciences, Kansas City, Mo., 1966. Internship, Grandview Hospital, Dayton, 1967. Residency, Doctors Hospital, Columbus, Ohio, 1974. Board certified.

**Van Grouw, Richard A.**, Cardiology. Medical education, UAMS, 1979. Internship/Residency, UAMS, 1984. Board certified.

**Williams, Robin C.**, Internal Medicine/Pediatrics. Medical education, Louisiana State University Medical Center, New Orleans, 1989. Internship/Residency, LSU, 1993. Board certified.

## BENTONVILLE

**Cuchia, John E.**, Anesthesiology. Medical education, University of Texas Medical Branch, Galveston, 1976. Internship/Residency, Children's Medical Center, Dallas, 1979. Residency, Parkland Memorial Hospital, Dallas, 1992. Board certified.

## EL DORADO

**Ong, Tie Sing**, Radiology. Medical education, Friedrich Alexander University, Erlangen, Germany, 1970. Internship/Residency, Dallas, 1978. Board certified.

## FORT SMITH

**Ashcraft, Cynthia**, Pediatrics. Medical education, UAMS, Little Rock, 1985. Internship/Residency, Arkansas Children's Hospital, 1988. Board certified.

**Marsh, Michael A.**, Otology. Medical education, Medical College of Virginia, Richmond, 1984. Internship/Residency, Baylor College of Medicine, 1991. Board certified.

## HELENA

**Paine, Johnny R.**, General Practice. Medical education, University of Health Sciences, Kansas City, Missouri, 1983. Internship, Charles Still Hospital, Jefferson City, Mo., 1984.

**Rangaswami, Bharathi**, Family Practice. Medical education, Venkateswara University, Tirupati, Andhra, India, 1967. Internship/Residency, Government General Hospital, Madras, India, 1969. Board certified.

## HOT SPRINGS

**Harrison, Margaret A.**, Pediatrics. Medical education, UAMS, 1963. Internship, University of Oklahoma Medical Center, Oklahoma City, 1964. Residency, UAMS, 1966. Board certified.

**Hitt, Wilbur Charles, Jr.**, OB/GYN. Medical education, UAMS, 1989. Internship/Residency, UAMS, 1993. Board eligible.

**Roda, Ferdinand T.**, Family Practice. Medical education, University of the East Roman Magsaysay Mem. Med. Center, Quezon City, Philippines, 1981. Internship/Residency, Medical college of Ohio, Toledo, 1993. Board certified.

**Tanganan, Priscilla**, Family Practice. Medical education, Southwestern University, Cebu City, Philippines, 1985. Internship/Residency, Flouren Memorial Hospital, 1993. Board eligible.

## HOT SPRINGS VILLAGE

**Lyles, Fred L.**, Family Practice. Medical education, UAMS, 1985. Internship, Baptist, Memphis, 1986. Residency, UAMS/AHEC-South, El Dorado, 1989. Board certified.

## LITTLE ROCK

**Adams, Christopher D.**, Rheumatology. Medical education, University of Alabama, Birmingham, 1981. Internship/Residency, USAF Medical Center, Wilford Hall, 1984. Board certified.

**Carle, Scott W.F.**, General Practice. Medical education, UAMS, 1984. Internship, AHEC-Fort Smith, 1985. Residency, Arkansas Children's Hospital, 1986.

**Caruthers, Carol S.**, General Practice. Medical education, UAMS. Internship, Baptist Medical Center, Little Rock, 1978.

**Hall, Richard W.**, Pediatrics. Medical education, UAMS, 1973. Internship/Residency, UAMS, 1976. Board certified.

**Mullens, Mark L.**, Cardiology-Internal Medicine. Medical education, University of Alabama, Birmingham, 1989. Internship/Residency, UAMS, 1993. Board certified.

## MARIANNA

**Waddy, Leon M., Jr.**, General Practice. Medical education, Meharry Medical College, Nashville, Tenn., 1972. Internship, Hulley Medical Center, Flint, Mich., 1979.



## MOUNT IDA

**Smith, Charles E.**, Family Practice. Medical education, UAMS, 1982. Residency, AHEC-Fort Smith, 1985. Board certified.

## ROGERS

**Aydelott, George A.**, Diagnostic Radiology. Medical education, University of Illinois, Peoria, 1978. Residency, UAMS, 1981. Board certified.

**Moffitt, Gary L.**, Family Practice. Medical education, UAMS, 1980. Internship/Residency, AHEC-Northwest, Fayetteville, 1984. Board certified.

## RUSSELLVILLE

**Hines, Cynthia R.**, Adult Hematology/Oncology. Medical education, University of Tennessee, Memphis, 1972. Internship, Baptist Memorial Hospital, Memphis, 1974. Residency, Eastern Virginia Medical School, Norfolk, 1976. Fellowship, Emory University School of Medicine, Atlanta, 1978. Board certified.

## SHERIDAN

**Winston, Scott D.**, Primary Care. Medical education, Ross University School, New York, 1983. Internship, University of South Dakota School of Medicine, 1985.

## OUT OF STATE

**Lux, Christopher L.**, Internal Medicine, Texarkana, Texas. Medical education, Texas Tech University, Lubbock, 1983. Internship/Residency, University of Oklahoma, Oklahoma City. Board eligible.

**Murray, Ian F.**, Radiology, Memphis, Tenn. Medical education, University of Tennessee, Memphis, 1969. Internship, Charity Hospital, New Orleans, 1970. Residency, University of Texas, San Antonio and Baptist Memorial Hospital, Memphis, 1974. Board certified.

**Peckham, Richard W.**, Internal Medicine, Texarkana, Texas. Medical education, University of Texas Southwestern Medical School, Dallas, 1978. Internship/Residency, University of Alabama, Birmingham, 1982. Board certified.

**Shefa, A. Zia**, General Practice, Broken Bow, Oklahoma. Medical education, University of Afghanistan, Kabul, Afghanistan, 1971. Internship, St. Paul Hospital, Dallas. Residency, Methodist Hospital of Dallas.

**Wright, Nathan L.**, Pediatrics, Texarkana, Texas. Medical education, UAMS, 1960. Internship, U.S. Naval Hospital, Portsmouth, Virginia, 1961. Residency, University of Tennessee, Memphis, 1967. Board certified.

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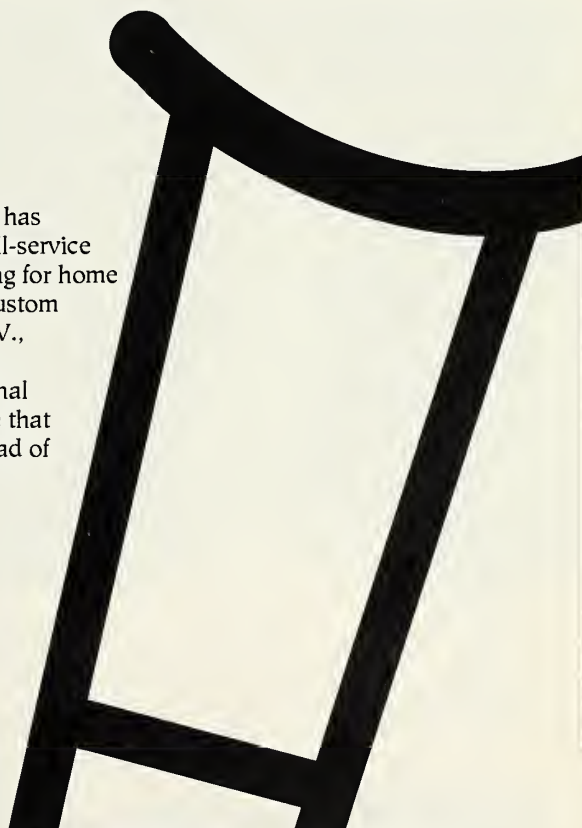


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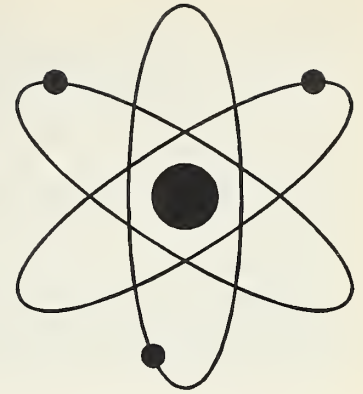
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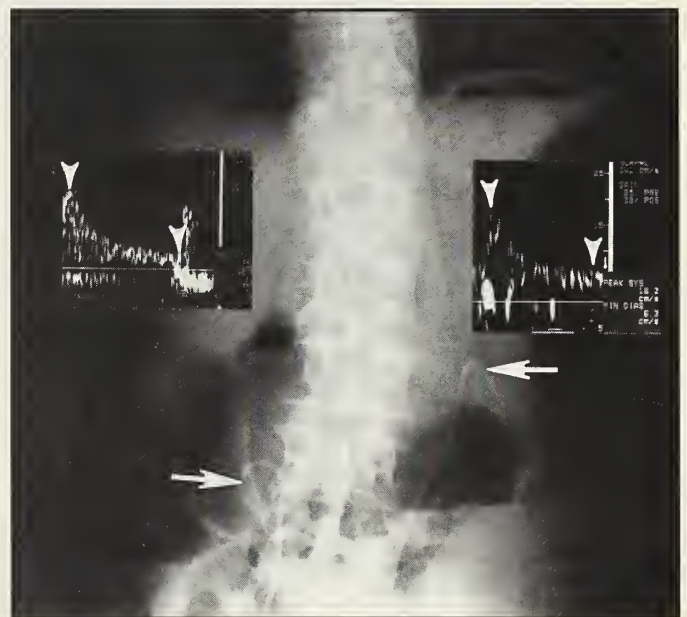
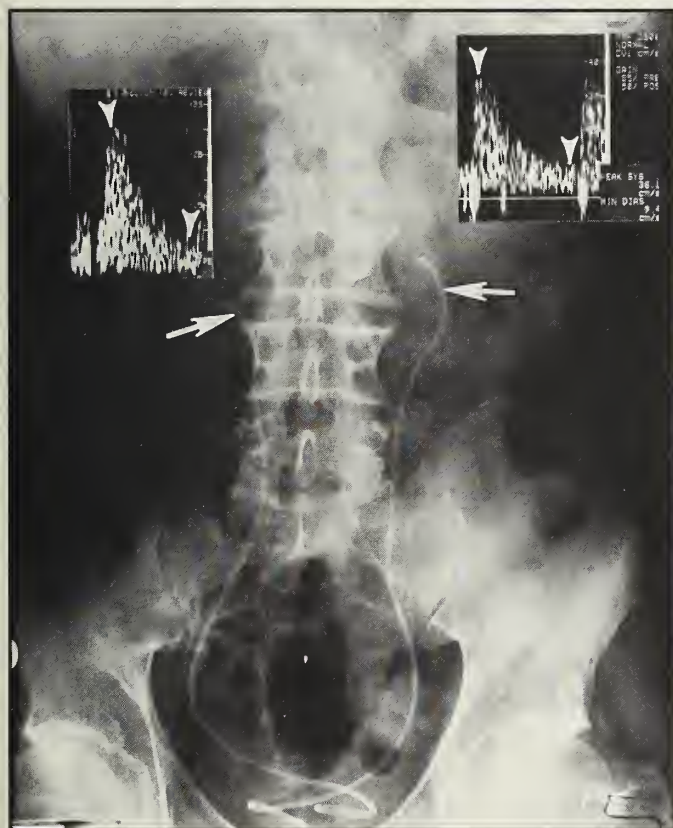
# Radiological Case of the Month



David L. Harshfield, M.D.  
Sam Houston, M.D.

## History:

This elderly gentleman had a history of chronic bilateral nephrolithiasis, the most recent bout of which necessitated bilateral ureteral stent placement. Figures 1 and 2 are abdominal films several days apart demonstrating stent placement with accompanying Doppler waveforms for each kidney.



Left: Figure 1  
Above: Figure 2

# Hydronephrosis of right kidney after stent migration.

## Findings:

Figure 1 demonstrates the stents to be in adequate position and the Doppler waveforms reveal normal, symmetric resistive indices of 0.7. Figure 2 shows distal migration of the right stent and the resistive index increased to 0.85 in that kidney (note diminished diastolic flow) with the left remaining unchanged.

## Discussion:

In this era of ESWL (extracorporeal shock wave lithotripsy) for renal stones, ureteric stent placement is a common procedure. This is done to ensure stone fragment passage and prevent obstruction of the collecting system. Solid material (such as stone fragments) in the renal pelvis and ureter stimulates peristalsis. This can result in caudal stent migration and subsequent ureteropelvic junction obstruction. Stent migration can be documented radiographically, but ultrasound may be required to determine if the patient is obstructed and requires stent repositioning. A dilated collecting system by grayscale, however, is not synonymous with hydronephrosis. This is particularly true in patients with a history of reflux, infection or chronic stone formation. The Doppler waveform can help differentiate nonobstructive dilation of the collecting system from true hydronephrosis. As in this patient, an elevated resistive index (0.85 on the right vs. 0.65 on the left) documenting obstruction. Unfortunately, not every case is as straight forward as this. This patient had baseline resistive indices with which to compare the "post migration" waveforms. This is most important if bilateral obstruction is a possibility, otherwise with unilateral stones, the contralateral renal waveform can be used for comparison. The following is an overview of the current literature on intra-renal duplex.

## Intra-renal Duplex in Hydronephrosis: Pathophysiologic Basis of Disease

### Significance

- 1) Evaluation of the dilated, possibly obstructed, kidney.
- 2) Not sensitive or specific enough to replace biopsy in predicting pathophysiologic causes of nonobstructive disease.
- 3) Application in medical renal disease:
  - a) Monitor patients with renal disease known to increase RI (resistive index).
  - b) Differentiate between renal diseases known to produce specific Doppler changes.

Sonography alone provides important anatomic information but does not address physiologic information related to renal arterial resistance.

### Technique

Doppler studies with conflicting results can be traced to differences in equipment and technique. Pathologic processes produce the most significant duplex alterations in the small vessels at the corticomedullary junction (arcuate and intralobular) and borders of the medullary pyramids (interlobar). Likewise, altered renal blood flow secondary to obstruction involves the cortex of the

kidney more than the medulla. A 5.0 MHz or lower frequency transducer requires critical attention to sample volume size, wall filter setting and pulse repetition frequency. Distal intrarenal vessels have lower flow velocities requiring a very low wall filter for detection. The lowest PRF that does not produce aliasing will optimize the spectral waveform size. Three distinct vessels from each kidney should be examined by obtaining three consecutive similar-appearing waveforms. Unlike the abnormal systolic upslope in Tardus-Parvus waveform easily assessed by simple pattern recognition, the RI must be calculated to accurately assess end-organ resistance.

### Normal Patterns

The four largest series of normal native kidneys report a mean RI:

- 1)  $.58 \pm .05$  (109 kidneys)
- 2)  $.64 \pm .05$  (42 kidneys)
- 3)  $.58 \pm .04$  (30 kidneys)
- 4)  $.62 \pm .04$  (56 kidneys)

The upper limit of normal mean intrarenal RI is 0.7. A normal creatinine does not necessarily indicate normal kidney function. A 50% decrease in renal function



can occur before serum creatinine levels exceed normal levels. This can result in apparently discrepant results in patients with "normal" creatinine levels and elevated RI's. Doppler may be more sensitive than creatinine levels in evaluation of patients with a dilated pelvocalyceal system.

A dilated collecting system is not synonymous with obstruction. There are three phases of hemodynamic changes associated with significant obstruction:

- Phase 1 ( $\uparrow$  ureteral pressure,  $\downarrow$  RVR)

In the first 1 to 2 hours, there is an increase in blood flow secondary to prostaglandin mediated vasodilation, thus abnormal RI is not present early because RVR (renovascular resistance) is actually lower than usual.

- Phase 2 ( $\uparrow$  ureteral pressure,  $\uparrow$  RVR)

Over the next 2 to 3 hours, there is increased postglomerular renovascular resistance, decreased blood flow and increased ureteral pressure. No other phase is associated with simultaneous increase in RVR and collecting system pressure. The RI is elevated during this phase.

- Phase 3 ( $\downarrow$  ureteral pressure,  $\uparrow$  RVR)

RVR continues to rise as ureteral pressure drops. There is increasing preglomerular resistance accounting for the increasing RI. The impression that the increased RI is associated with increased pressure in the collecting system is, therefore, inaccurate. This increasing RI occurs in denervated transplants, thus it is not secondary to some nervous system reflex.

### Pathophysiology of Hydronephrosis

At 4 hours, peaking at 24 hours, a mononuclear cell interstitial infiltrate (macrophages) releases thromboxane A<sub>2</sub> (TXA<sub>2</sub> is a vasoconstrictor not found in normal kidneys) into the renal cortex. This increase in RVR may ultimately produce permanent renal failure if the obstruction is not relieved. Pyelocaliectasis is not necessarily indicative of obstruction (e.g., reflux) and therefore does not produce increased RVR. A series of 229 kidneys revealed RI's in obstruction of  $0.77 \pm 0.5$ . A dilated collecting system with RI of 0.7 or greater indicates obstruction, less than 0.7 suggests nonobstructed dilation. The sensitivity of 0.7 is 95%, specificity 88%, and accuracy 90% in diagnosing significant obstruction.

### Correction of Hydronephrosis

The duration of obstruction determines the length of time the vascular changes will be observed. If corrected prior to the end of phase 2 (5 hours), the RVR rapidly reverts (RI normalizes). Obstruction greater than 24 hours may result in days to weeks before RI's return to normal. Post-nephrostomy placement RI's should decrease in 3-10 days if renal dysfunction is not permanent.

### Partial Obstruction

The Whitaker test has been the gold standard to predict obstruction significant enough to result in renal atrophy and nephron loss. Significant obstruction is associated with TXA<sub>2</sub> mediated vasoconstriction; however, mild or partial obstruction is characterized by prostaglandin mediated vasodilation. There may be pyelocaliectasis without increased RVR or atrophy. In fact, the presence or degree of dilatation does not correlate with nephron loss or cortical atrophy. This is not surprising, since mild ureteral narrowing occurs that is sufficient to produce a delayed renogram but normal Whitaker test.

### Pitfalls

It is not uncommon to obtain a "normal" RI ( $<0.7$ ) in an acutely ( $\leq 8$  hrs.) obstructed kidney. Comparison with a nondilated contralateral kidney should reveal a difference of 0.10 or greater. An abnormal RI ( $> 0.7$ ) should be observed by 24 hours.

In severe chronic obstruction, after significant parenchymal loss there is less elevation in RVR, due to absence of the interstitial infiltrate mediated vasoconstriction. The RI may therefore return to normal or at least be similar to the unaffected kidney.

In children, RI's due to bulky juxtaglomerular cells interfering with renal blood inflow are normally higher than in adults.

In patients with medical renal disease and pyelocaliectasis, an elevated RI could be due either to obstruction *or* end organ disease with coexistent nonobstructive dilatation. If the patient has obstruction superimposed on medical renal disease, the RI should be increased by 0.10, compared with the nondilated contralateral kidney. If a patient with bilaterally increased RI's has bilateral dilatation and echogenic kidneys (an uncommon situation) duplex is not effective in discriminating between these processes.

## Nonobstruction Renal Disease

### Hypertension

RI's may be increased in renovascular disease, but are not predictive of the presence or degree of renal artery stenosis. In fact, the RI should be lower than the contralateral kidney ( $\leq 0.10$ ) in healthy kidneys downstream from a hemodynamically significant stenosis. Further, a Tardus-Parvus (slow) upstroke associated with a high RI is a poor prognostic indicator for successful revascularization of that kidney.

### Renal Vein Thrombosis

Doppler interrogation of the main renal vein can be difficult. In significant acute RVT, the intrarenal edema from venous obstruction results in increased resistance. There is also a mononuclear interstitial infiltrate stimulating TXA<sub>2</sub> synthesis, similar to the circumstance in hydronephrosis, resulting in increased resistance.

## Medical Renal Disease

Adult kidneys are imaged with transducers of 5 MHz or less. The scatterers are approximately 200 microns in size; glomeruli are 200 microns in diameter. Bright kidneys are therefore secondary to glomerular disease. The findings of hyperechoic kidneys, unfortunately, are nonspecific findings. Acute disease histologically shown to be limited to the glomeruli have been shown to have normal RI's. Increased RI's occur with active disease in the tubulointerstitial and/or vascular compartment of the kidney. Acute and subacute glomerulonephritis produce a vasodilatory prostaglandin response accounting for absence of increased RI's in that disease. Increased RI's correlate with chronic glomerular disease (glomerulosclerosis), vascular intrarenal disease, interstitial edema and interstitial fibrosis. Duplex cannot replace renal biopsy, nor can it be used as a screening tool for end organ disease. The two most important current uses for duplex in medical renal disease are:

- 1) Longitudinal follow-up.
- 2) Differentiate two similar disease such as hemolytic uremic syndrome, which increases RI, from forms of acute renal failure, which generally do not.

## Acute Renal Failure

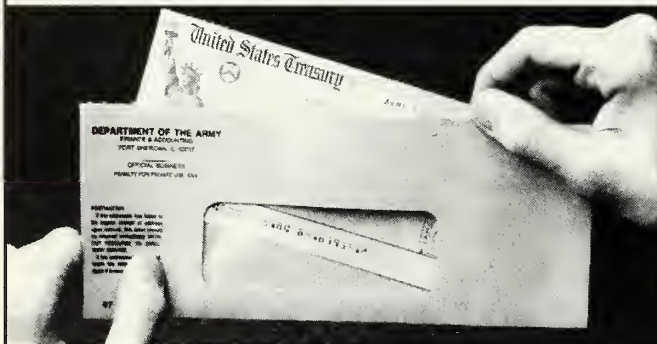
Grayscale sonography for ARF to rule out obstruction is a commonly performed, but rarely positive, exam. Obstruction is a rare cause of ARF, thus most of these studies are normal. However, increased RI's occur in 70% of these patients, indicating the importance of obtaining duplex exams as well as grayscale imaging in these patients. The two leading causes of ARF are ATN (with mean RI of 0.85) and acute prerenal azotemia (mean 0.67). Ninety-five percent of ATN patients have increased RI's mean of 0.85 or greater; only 20% of patients with acute prerenal failure exceed this level. (*Chronic* prerenal failure may result in increased RI's.) The increased RVR and decreased blood flow in ATN are secondary to sustained afferent arteriolar vasoconstrictions similar to the situation in hydronephrosis, thus resistance varies according to the time frame (phase) of the disease process.

## Conclusion

RI is increased in obstruction, renal vein thrombosis, hemolytic uremic syndrome, ATN and non-glomerular medical renal disease. ■

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**Dr. John Deaton**, who is associated with the cardiology department at Holt-Krock Clinic, has been named 1994 chief of medical staff at Sparks Regional Medical Center. **Dr. Annette Landrum**, a member of the Sparks Regional Medical Center Department of Pathology and a partner in Laboratory Medicine Associates, has been named chief of staff-elect.

**Dr. David V. Ewart**, an internist in Siloam Springs, has been appointed as the new chief of staff of the Siloam Springs Memorial Hospital.

**Dr. J.E. Kelsey**, retired physician in Fort Smith, was recently honored when Sparks Regional Medical Center dedicated its labor and delivery area to him. Dr. Kelsey was the first obstetrician in western Arkansas to be certified by the American Board of Obstetrics and Gynecology.

**Dr. Mike S. McFarland** of Pine Bluff made several presentations at the 15th Annual Royal Hawaiian Eye Meeting held in Maui in January. The goal of the annual meeting is to guide participants to improve their own medical practice based on the latest clinical studies in the areas of cataract, glaucoma and refractive diagnosis, including new medical therapies and innovative surgical techniques.

**Dr. Robert Miller** of Helena has been appointed to the National Advisory Committee on Rural Health of the Health Resources and Services Administration.

The appointment was made by Donna E. Shalala, Secretary of Health and Human Services in Washington, D.C. The National Advisory Committee on Rural Health is an 18-member panel of nationally recognized rural health experts chartered in 1987 to advise the Secretary of Health and Human Services on ways to address health care problems in rural America.

**Dr. E. Mitchell Singleton**, a Fayetteville ophthalmologist, recently spoke at Vision Quest '94, a continuing education lecture series held in Cancun, Mexico. The lecture was the national corporate meeting for Texas State Optical, Inc., of Beaumont, Texas. Singleton presented current updates on diabetic and geriatric eye conditions and concerns.

**Dr. Robert B. White**, of Paragould, was recently chosen as one of two individuals representing the Arkansas Affiliate of the American Heart Association at a National Affiliate Healthsite Team Conference. The con-

ference was held at the American Heart Association's National Center in Dallas, Texas.

At the two-day meeting, staff members and both lay and medical volunteers from Heart Association affiliates in several states were asked to review, critique, modify and approve various programs and educational materials proposed for use nationally by the association.

**Dr. Steven Wilson**, a Fort Smith and Van Buren urologist and fellow of the American College of Surgeons, recently was asked to appear on "Kilroy," a British Broadcasting Co. talk show, to refute the medically unproven concept of an English physician whose practice emphasizes a controversial treatment of male menopause with male hormone. He was asked to make the appearance while teaching treatment of impotency in seven England hospitals.


### Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the month of February are:

William E. Atkinson	Little Rock
Robert L. Fincher	Little Rock
William F. Hayden	Little Rock
Connie Hiers	Jonesboro
Hosea W. McAdoo	Little Rock
Eugene F. Still	Fort Smith
Gerald N. Weiss	Little Rock
Morton C. Wilson	Fort Smith

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This year the guard changes at Searcy Medical Center, as Wayne retires to work on his golf game and spend more time with his grandchildren. Wayne's successor, Al Fowler, doesn't foresee any insurance changes. "I'm looking forward to working with The Medical Protective Company and MGIS," he says. "They've done a good job helping our clinic and our physicians deal with the realities of our business. We are all very comfortable with them."

The MGMA Group Professional Liability Program is underwritten by The Medical Protective Company, the nation's oldest professional liability underwriter. Founded in 1899, The Medical Protective Company has over one billion dollars in assets and a continuous A+ (Superior) rating from A.M. Best as well as a AA rating from Standard & Poor's.

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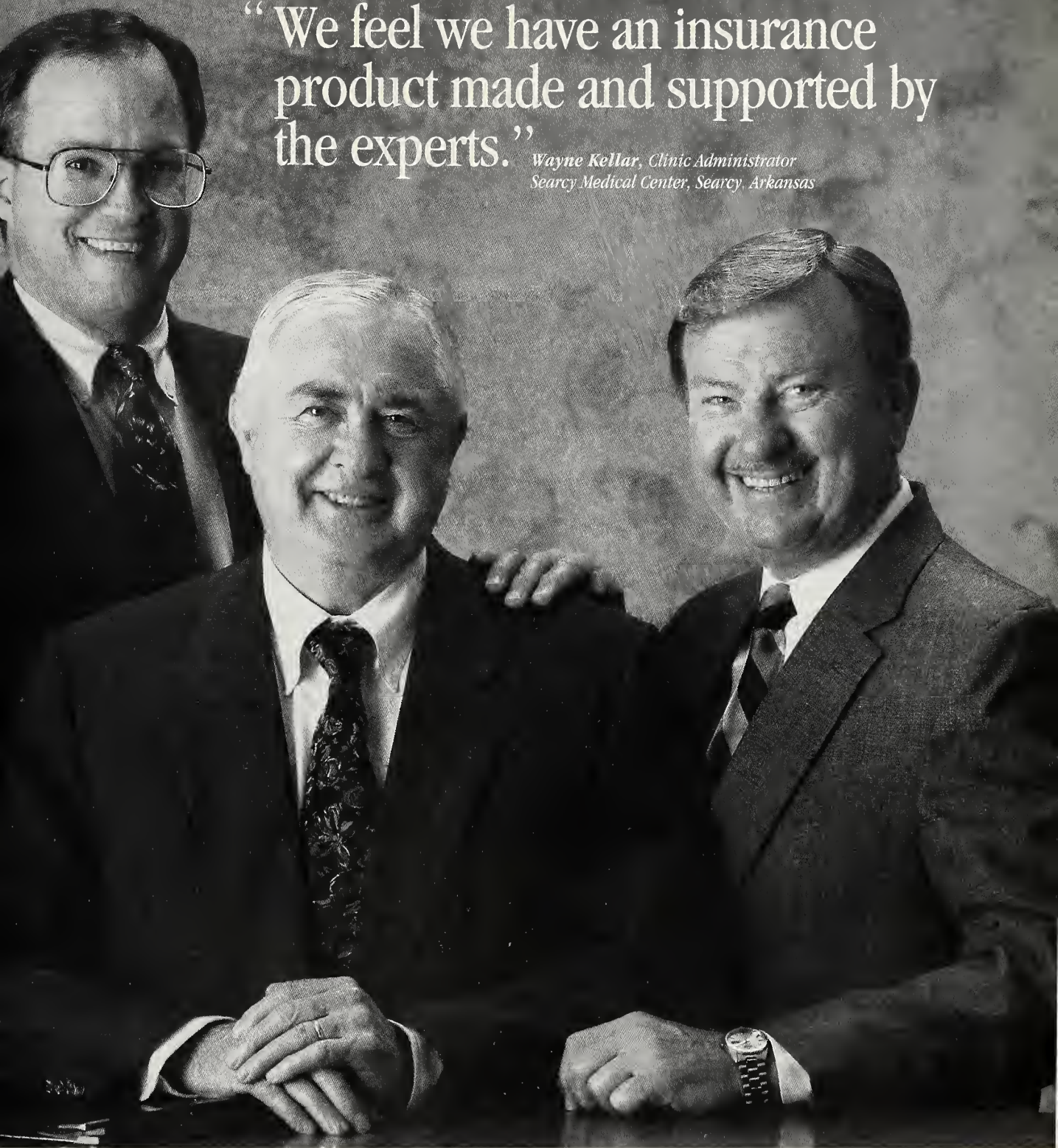




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*Wayne Kellar, Clinic Administrator  
Searcy Medical Center, Searcy, Arkansas*



*In 1973 four internal medicine physicians joined four family practice physicians to form the Searcy Medical Center. In twenty years the group practice has grown to include 19 physicians and 66 employees, offering a wide range of medical services to the people of central Arkansas.*

*Pictured from left to right:*

*Al Fowler, of Searcy Medical Center; Wayne Kellar, of Searcy Medical Center; and Bill Starkey, of The Medical Protective Company.*

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## Health Care Access Foundation Update

As of February 1, 1994, the Arkansas Health Care Access Foundation has provided free medical service to 7,240 medically indigent persons, received 13,820 applications, and enrolled 28,038 persons.

This program has 1,634 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 69 of the 75 counties.

## WLF Petitions Arkansas Supreme Court to Reform Lawyer Advertising Rules

The Washington Legal Foundation (WLF) recently petitioned the Arkansas Supreme Court to amend its rules relating to lawyer advertising and solicitation in order to ensure that consumers are protected against misleading and fraudulent attorney advertising.

"Misleading attorney advertising is rampant. For example, attorneys regularly advertise for clients by promising 'no fee except on recovery' - without warning that the potential client might incur considerable expenses if the client files suit and does not prevail," said WLF General Counsel Daniel Popeo after filing the petition. "Furthermore, attorney advertising often encourages the filing of frivolous lawsuits or the charging of excessive attorney fees, all of which have a negative impact on consumers, business and the economy," Popeo said.

WLF's petition is part of WLF's SCALES project ("Stop the Collapse of America's Legal Ethics"), a nationwide program designed to eliminate abuse in America's civil justice system. To date, the SCALES project has been focused on two distinct areas: attorney advertising and the contingency-fee system. The Arkansas petition is WLF's 27th that addresses attorney advertising. WLF has filed petitions in 39 states (including Arkansas) addressing contingency fee reform which will curb the use of excessive contingency fees, especially where liability is clear, and thus, no contingency or risk of non-recovery exists. In such cases, a client should be charged only a reasonable hourly rate rather than a "one-third" contingency fee which results in effective hourly rates of up to \$10,000 an hour.

Among the key provisions of WLF's attorney advertising petition are provisions:

1. Prohibiting lawyers from directing any form of solicitation to a potential personal injury plaintiff for a period of 30 days following the death or injury giving rise to the potential claim;

2. Requiring all advertisements or solicitations that state that legal services are available on a contingent or no-recovery-no-fee basis to also state that the client may be responsible for costs, expenses, or court-imposed sanctions; and
3. Requiring that written solicitations contain the words "Advertising Material" on the top of each page and that copies of solicitations be filed with bar authorities.

## The St. Paul Pioneers Disaster Recovery Kit for Health Care Practices

In the wake of recent hurricanes, floods and fires of incredible destructive power, St. Paul Medical Services is launching a unique disaster planning kit designed specifically for the health care environment.

### Inspired by Disaster

The health care community's concern regarding disaster recovery has been dramatically raised by the unusual number of disasters that have occurred during the past five years.

"We recognized that the health care practitioners who fared best during recent catastrophes were those that had disaster recovery plans in place," said Tim Morse, vice president-underwriting, St. Paul Medical Services. "But these practitioners took it upon themselves to prepare a plan. There was no 'off-the-shelf' disaster recovery planning product specifically designed for small- to medium-size medical and dental practices. Diagnosis Disaster fills that void.

"When physicians complete this kit, they will have a basic disaster recovery plan in place and ready to use in the event of a disaster. They don't have to waste time working through the complicated planning process. We've done that for them. Diagnosis: Disaster simplifies the process and even explains how to test the plan's effectiveness before disaster strikes."

### The Office Planning Grid

A unique feature of the kit is the "Office Planning Grid," a tool to help health care practitioners visualize their practices' vulnerability to various kinds of disasters. Using an erasable pen included with the kit, practitioners draw the layout of their facility on the grid and apply "icon stickers" to mark the location of medical records, equipment, supplies, medications and other important components of their practice setting. Disaster icons are used to indicate the kinds of disasters most likely to affect their offices. The grid can also be used to plan evacuation routes for patients and staff.



**Quick-Reference Features**

Diagnosis: Disaster also includes specialized fill-in-the-blank worksheets that help users compile crucial information they need before, during and after a catastrophe. The worksheets are then incorporated into a practice's disaster recovery plan, providing easy access and quick reference in the event of a disaster.

Another quick-reference feature of the kit is a collection of "Disaster Tip Sheets." Each tip sheet outlines instructions tailored for a specific type of disaster, including tornadoes, earthquakes, floods, fires, bomb threats and civil disturbances. Based on the type of disasters to which an office is prone, appropriate tip sheets can be incorporated into a practice's individual plan.

In addition to the Office Planning Grid, specialized worksheets and Disaster Tip Sheets, the kit includes three brief narrative sections - Analysis, Action and Recovery - that guide readers through the disaster recovery planning process.

**Eliminating "Disaster Paralysis"**

"We've found that health care practitioners are sometimes overwhelmed by the disaster planning process," said Morse. "Yet, without a plan, a disaster can make relatively basic tasks, such as contacting patients, vendors and insurance companies, very difficult. Complicated tasks, such as relocating an office and hiring temporary help seem impossible. People become paralyzed. Diagnosis: Disaster will help our policyholders avoid that paralysis by providing an easy step-by-step guide to disaster recovery planning."

The St. Paul is offering Diagnosis: Disaster on a complimentary basis to its policyholders; physicians insured by other insurance companies may purchase the kit from The St. Paul for \$35. (To order, send a check or money order for \$35 to "Diagnosis: Disaster," St. Paul Medical Services, 385 Washington Street, St. Paul, MN 55102.)

**In Memoriam** \_\_\_\_\_

**Irene Zwisler Dozier**

Irene Zwisler Dozier, of Marianna, died Sunday, March 13, 1994. She was 95.

She was the widow of the late Dr. Floyd Spivey Dozier. Survivors include several nieces and nephews.

**Bland Robert Harper, M.D.**

Dr. Bland Robert Harper, of Monette, died Thursday, February 15, 1994. He was 82.

Survivors include his wife, Roma; sons, Bob and Pat Harper; daughter, Lisa Beck; sisters, Bernice Baker and Muriel Dryer; and six grandchildren.

**William Sexton Lewis, M.D.**

Dr. William Sexton Lewis, of Little Rock, died Monday, March 14, 1994. He was 63.

He is survived by his wife Glenda Hatman Lewis of Little Rock; one son, John Lewis of Fort Wayne, Indiana; one daughter, Sarah James of Little Rock; one brother, Dr. Ronald Lewis, of Lake Charles, La.; and his stepfather, Orben Taylor of Mayflower, Arkansas.

**Joe Hillman Poff, M.D.**

Dr. Joe Hillman Poff, of Heber Springs, died Monday, February 21, 1994. He was 68.

Survivors are his wife, Aveline; three sons, Joseph Hillman Poff, Jr., and John Lloyd Poff, of Heber Springs, and James Richard Poff of Trumann; two brothers, Frank Poff of Hot Springs and Dr. Nathan Poff of Heber Springs; two sisters, Reba Jean Estes of El Paso, Texas and Margaret Leo Gary of St. Joseph, Louisiana; and four grandchildren.

**N. Henry Simpson, Jr., M.D.**

Dr. N. Henry Simpson, Jr., of Little Rock, died Tuesday, February 22, 1994. He was 75.

Survivors include his wife, Virginia Watson Simpson; two sons, N. Henry Simpson, III of Dallas, Texas and Eugene Thomas Simpson of Silverthorne, Colorado; two daughters, Rebecca Sue Haines of Denver, Colorado and Mary Virginia Daily of Van Buren, Arkansas, and twelve grandchildren.



# Things To Come

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## **April 28-30**

**Federation of State Medical Boards Annual Meeting.** Grand Hyatt, Washington, D.C. For more information, call George Washington University Medical Center, (202) 994-4285.

## **April 28-30**

**Primary Care Symposium III.** Hotel Intercontinental, New Orleans. Sponsored by the Hispanic/American Medical Association of Louisiana and the Tulane University Medical Center. For more information, call Office of CME, (504) 588-5466 or (800) 588-5300.

## **April 29**

**3rd Annual Pathology Forum.** UC Davis Medical Center, Cancer Center Auditorium, Sacramento, California. Sponsored by the Office of Continuing Medical Education. For more information, call (916) 734-5390.

## **April 29-30**

**Current Topics in Pathology IV: Hematopathology.** Westin Canal Place Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## **April 29-May 1**

**Pediatric Update for the Primary Care Physician.** Westin Canal Place Hotel, New Orleans. Sponsored by Tulane University Medical Center. For more information, call (504) 588-5466 or (800) 588-5300.

## **April 30**

**Cancer in Women: Management of Breast and Gynecologic Malignancies for Health Practitioners Treating Women.** Cancer Center Auditorium, UC Davis Medical Center, San Francisco. For more information, call (916) 734-5390.

## **April 30**

**Cancer Update 1994: On the Cutting Edge of Medicine.** Doubletree Hotel, New Orleans. Sponsored by the Alton Ochsner Medical Foundation and the American Cancer Society, Louisiana Division. For more information, call Ms. Ginny Barden at (504) 469-0021.

## **May 8-13**

**26th National Conference on Breast Cancer.** Marriott's Desert Springs Resort & Spa, Palm Desert, California. Sponsored by the American College of Radiology. For more information, call (800) 331-3112

## **May 12-14**

**Ambulatory Surgery '94: Healthcare Reform - Challenges and Opportunities.** Marriott Orlando World Center, Florida. Sponsored by the Federated Ambulatory Surgery Association. For more information, call (703) 836-8808.

## **May 13-14**

**Coming of Age: Geriatrics for the Primary Care Provider.** Sacramento Inn, Sacramento, Calif. Sponsored by Office of CME, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## **May 20-21**

**Contemporary Topics in Cardiothoracic Anesthesia.** Washington University Medical Center, Wohl Auditorium, St. Louis, Missouri. Presented by the Division of Cardiothoracic Anesthesia and the Office of Continuing Medical Education, Washington University School of Medicine. For more information, call (800) 325-9862.

## **May 20-21**

**Functional Endoscopic Sinus Surgery.** Tulane School of Medicine, New Orleans. For more information, call the Office of CME at (504) 588-5466 or (800) 588-5300.

## **May 21**

**The Fifth Annual Rush Symposium on Transplantation.** Claude H. Searle Conference Center, Rush-Presbyterian-St. Luke's Medical Center, Chicago. For more information, call (312) 942-3114.

## **June 3-4**

**Apheresis Update 1994.** Stouffer Concourse Hotel, Arlington, Virginia. Sponsored by the American Association of Blood Banks, Society for Hemapheresis Specialists and the American Society for Apheresis. For more information, call (301) 215-6482.

## **June 5-10**

**3rd Annual New Orleans Anesthesiology Comprehensive Review & Update.** Hyatt Regency, New Orleans. Category I credit: 42 hours. For more information, call (504) 588-5466 or (800) 588-5300.

## **June 8-12**

**Invasive Surgery: Is It Obsolete? 56th Annual Meeting of the International College of Surgeons-**



United States Section, Stouffer Tower City Plaza Hotel, Cleveland, Ohio. For more information, call (312) 787-6274.

**June 9-10**

**Treatment Strategies for the Oncology Patient: Expanding Horizons in Transfusion Medicine.** Hyatt Regency, Bethesda, Maryland. Sponsored by the American Association of Blood Banks, the Transfusion Medicine Academic Award Program and the Transfusion Medicine Specialized Center of Research Program of the National Heart, Lung, and Blood Institute. For information, call (301) 215-6482.

**June 9-11**

**4th Annual Meeting of the Southern Association for Geriatric Medicine.** Westin Resort, Hilton Head, South Carolina. For more information, call (205) 945-1840.

**June 11-15**

**2nd Annual Board Review Course in Family Medicine.** Crystal Gateway Marriott Hotel, Arlington, Virginia. Sponsored by the George Washington University Medical Center, Office of CME. Fee: \$650, physicians. For more information, call (202) 994-4285.

**June 17-18**

**National Blood Inventory Management Conference.** Hyatt Orlando, Florida. Sponsored by the American Association of Blood Banks, Florida Association of Blood Banks, the Council of Community Blood Centers and the American Red Cross. For information, call (301) 215-6482.

**June 23-25**

**1st Annual Meeting of the Southern Association for Family Practice.** The Woodlands, Williamsburg, Virginia. For more information, call (800) 423-4992.

**July 15-16**

**Hand Review '94.** Holiday Inn, Capitol Plaza, Sacramento, Calif. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

**July 16-22**

**19th Annual National Wellness Conference.** University of Wisconsin, Stevens Point, Wisconsin. For more information, call (800) 243-8694.

**July 28-30**

**7th Annual Meeting of the Southern Association for Oncology.** Jekyll Island Club Hotel, Jekyll Island, Georgia. For more information, call (205) 942-0530.



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## **Advances in the Diagnosis and Management of Breast Cancer**

*April 14-16, 7:30 a.m., registration and continental breakfast, Statehouse Conference Center, Little Rock. Sponsored by UAMS and the American Cancer Society. Presented by Suzanne Klimberg, M.D. Category I credit: 13.5 hours. Fee: \$300 for physicians. For more information, call 686-6503.*

## **Arkansas Perinatal Association**

*April 18, time and location to be announced. Sponsored by UAMS College of Medicine and presented by Russell Kirby, M.D.*

## **Advances in Cardiology**

*April 19, 6:30 p.m., Baxter County Regional Hospital Education Building, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Paul Freiman, M.D. No fee; Category I credit: 2.0 hours.*

## **W.W. Stead Chest Symposium**

*April 23, time to be announced, Holiday Inn-City Center, I-630 & Broadway, Little Rock. Sponsored by UAMS College of Medicine; presented by Marcia Erbland, M.D.*

## **Diabetes Update**

*May 7, Registration 8:00 a.m., Hilton Inn, Little Rock. Sponsored by University of Arkansas for Medical Sciences and presented by Vivian Fonseca, M.D.*

## **Deep Vein Thrombosis and Pulmonary Embolism**

*May 17, 6:30 p.m., Baxter County Regional Hospital Education Building, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Robert Lavender, M.D. No fee; Category I credit: 2.0 hours.*

## **Perspectives in Pain Management**

*May 19, Statehouse Convention Center, Little Rock. Sponsored by Arkansas Hospice Association, American Cancer Society and Arkansas Cancer Pain Initiative. For more information, call 664-3480.*

## **Sixteenth Annual Family Practice Intensive Review**

*June 3-5, time to be announced, UAMS, Little Rock. Sponsored by UAMS and presented by Jerry Mann, M.D. and Mary Lindsey, L.C.S.W.*

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **FAYETTEVILLE-VA MEDICAL CENTER**

*General Medical Topics, Thursdays, 12:00 noon, Auditorium, Bldg. 3  
Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*Continuing Medical Education Luncheon, Apr. 22, May 13 & 27, June 10 & 24, 12:30 p.m., AMI Ozark - Quapaw Room*

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom*

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Cancer Conferences, Thursdays, 12:00 noon, location to be announced. Lunch provided.  
Chest Conference, 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
General Surgery Grand Rounds, 1st Thursday, 7:00 a.m. Smith Room. Light breakfast provided.*



*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.  
*Journal Club*, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Mental Health Conference*, 3rd Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided

#### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*Breast Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*GI Conference*, 4th Friday, 11:30 a.m., Conference Room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

#### **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Chest & Problems Case Conference*, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Medicine Conference*, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Surgery Conference*, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*X-ray Case Conference*, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

#### **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Family Practice Grand Rounds*, Tuesdays, 12:15 p.m., Family Practice Center, 6th and Elm  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33

*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS Jones Eye Institute, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Jones Eye Institute  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

#### **EL DORADO-AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

#### **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center  
*Medical/Surgical Conference Series*, 4th Tuesday, 12:30, Bates Medical Center, Bentonville  
*Primary Care Conferences*, 1st & 3rd Mondays, 12:00, every Tuesday 7:30 a.m., Washington Regional Medical Center



## **FORT SMITH-AHEC**

*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Thursdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Harris Hospital Tumor Conference*, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Orthopedic Case Conference*, every other month beginning April 28, 7:30 a.m.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
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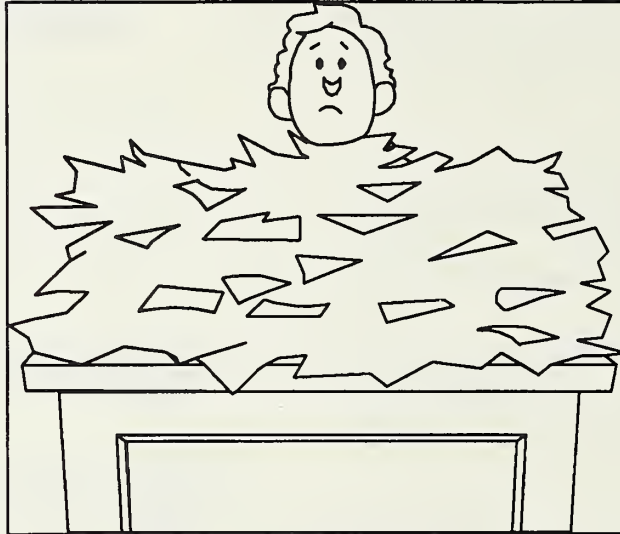
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# Children of Divorce in Arkansas

H. Patrick Stern, M.D.\*  
 Michael W. Mellon, Ph.D.\*\*  
 Beth O. Butler, LCSW\*\*\*

Behavioral Pediatrics is a subspecialty in pediatrics at the University of Arkansas for Medical Sciences which serves children and their families who have concerns about a child's behavioral, cognitive or physical functioning. In recent years, one of the most frequent reasons that we are consulted relates to behavioral concerns about children of divorce which often include questions about custody and visitation. Referrals may originate from a concerned parent, from an attorney or judge, or from other medical or mental health professionals. During the initial contact, we emphasize that we will focus only on the needs of the child or children, and that we must be permitted to include every adult who can help in the evaluation process, and any subsequently proposed treatments, if needed.

Frequently it is requested that we present our impressions and recommendations to the court. This may be done in a deposition, through a medical and psychiatric statement, or by testifying in a court proceeding. In recent years, this direct legal involvement has occurred on an almost weekly basis. We have worked with judges in courts throughout the state of Arkansas, and on occasion have been consulted by out of state legal systems. Based on this clinical work, we have witnessed tremendous variation in legal proceedings that relate to children of divorce.

The quality of legal proceedings serving children of divorce appears to depend most heavily on the judge. The role of the attorneys is nearly as important in determining whether the best interest of a child will be

served from a medical and psychiatric standpoint. It is impressive to see how an individual judge can be so thoughtful, thorough and sensitive in conducting a hearing to truly meet the best interest of the child. Likewise, it is impressive to observe attorneys who will focus on the best interest of a child when it may not be consistent with the initial goals of their client. When the wisdom of a judge is combined with attorneys who truly focus on the best interest of the child, legal proceedings appear to always render judgements which maximize the physical and emotional well being of children.

In striking contrast to these wise decisions, we have witnessed judgements which did not appear to focus on the needs of children of divorce. Following are some case histories from our work.

## Case Example #1

A two year old female was brought for evaluation because of sleep problems, temper tantrums, excessive clinging and non-compliant behavior. This child had been court ordered to alternately spend two months with her mother in Arkansas and then two months with her father in California. Our evaluation determined that this child was depressed because of the highly disruptive visitation arrangements. In spite of court testimony that the visitation schedule was the cause of the depression and a recommendation that the child needed a stable home to treat the depression, the court ordered the visitation to continue. The child continued to display the symptoms of the depression and ultimately was kidnapped by her father. She was found by the police a couple of months later and returned to her mother. She resumed therapy showing symptoms of post traumatic stress disorder.

## Case Example #2

Two girls, 7 and 8 years old, were referred for evaluation by the judge because there were allegations of

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sexual abuse perpetrated by their mother. A physician and psychologist, who had previously been involved in evaluating these children, had determined there was evidence the children had been sexually abused by their mother based on the children's statements as well as physical findings. The children had been placed in foster care for a number of months, and custody had been changed from the mother to the father. Our evaluation also concluded that these two girls had been sexually abused by the biological mother. It was also previously substantiated that the maternal grandfather had sexually abused these girls when they had been in the care of their mother. In spite of a recommendation given in court testimony that these girls should not be required to continue visitation with their mother until successful therapeutic interventions could be accomplished, these children were forced to continue visitation with her supervised only by a relative of the mother. Their mother was not ordered to engage in any therapy and refused to do so. Subsequently, an incident of physical abuse consistent the medical criteria occurred. Then, another incident of sexual abuse substantiated by the Arkansas Department of Human Services (DHS) happened. The girls were still required by the court to continue DHS supervised visitation with the mother, who still had received no therapy and was not court ordered to do so.

### Case Example #3

A guardian ad litem was appointed in a bitter custody battle of a school age brother and sister. The father, who was willing to go to marital counselling to restore a healthy marriage, was noted by the guardian ad litem to be showing evidence of grieving as manifested in periodic sadness and tearfulness. The attorney became critical of the father stating this was an indication that he was emotionally weak and would have difficulty being an adequate parent to his children. The mother, on the other hand, showed no emotion and was harshly critical of the father. During a discussion about our impressions and recommendations which supported the father being given caretaking of the children, the guardian ad litem spontaneously volunteered that she had gone through a recent divorce herself which had involved a custody dispute about her own child.

### Case Example #4

A three year old boy was evaluated for temper outbursts, physical aggression and clinging to his mother after a three month court ordered summer visitation with his father who lived in Italy. The parents had divorced when he was less than one year old. He had seen his father twice since the divorce prior to the three month summer visitation. During that visitation, he spoke to his mother only one time on the telephone, and her cards and letters were unanswered. When the

child returned, he told his mother that his father had touched his penis. There was an investigation of the alleged sexual abuse. During the evaluation, the child was forced to visit with the paternal grandparents who had been granted visitation rights. They were hostile towards the mother and told the child not to call his stepfather "Daddy." The evaluation provided information that supported the allegation that sexual abuse had occurred. Recommendations included that the child not be forced to visit the biological father or the paternal grandparents until therapeutically indicated. It was recommended that the father and paternal grandparents engage with the mother and stepfather in the child's therapy. An expert retained by the father gave opposing recommendations. The court granted custody to the mother, but continued month long summer visits with the father who had moved to California. It also upheld the grandfather's rights of every other weekend visitations. After the summer, the father moved back to Arkansas with his parents. Based on court ordered visitation with the father and paternal grandparents, the child was home only 22 days between October and January 1992. The remainder of the time was spent with his father and paternal grandparents including Halloween, Thanksgiving, Christmas and New Years. The father and paternal grandparents were not ordered by the court to engage in therapy and chose not to do so.

### Case Example #5

A 12 year old male was referred by his school counselor. He was brought in by his mother who had physical custody of this boy and his eight year old brother for five years. The boy had academic and behavioral problems at school with a school report stating he was "defensive," "lethargic," and "waiting to explode." He indicated he was fearful of his biological father's response to his poor school performance and that his biological father called him "stupid" when he got poor grades. Previous psychological testing revealed a severe learning disability. His mother indicated the father was an active alcoholic and was not interested in custody until he remarried. A few months prior to the evaluation, the children were put in joint custody. The boys were required to live two weeks with their mother alternating two weeks with their biological father, his new wife and her three children. The child indicated four boys slept in one room and the father had allowed the other children to whip him with a belt. The father also reportedly had left four children alone on a barge while he went to get lunch. The father refused to join in the evaluation and treatment. We were not involved in any legal action in this case.

### Case Example #6

A two year old girl was brought in by her mother



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for biting other children at daycare and excessive clinging. She would scream and protest when going on visitation with her father, who refused to permit her to bring her blanket or pacifier. Her parents had been divorced since she was six weeks of age. Visitation with the father was every noon for one hour during the week, Wednesdays between 5:00 and 7:30 p.m., and Sundays between 10:00 a.m. and 5:00 p.m.

Severe tension existed between the biological parents related to the father who had attempted to coerce the mother to abort the child. There were also marked differences in each parent's style of child rearing. The father had made a suicidal gesture while driving with his wife before the divorce and had physically abused the mother. His own parents had no interaction with him, reporting serious problems during his upbringing. They expressed grave concerns about his emotional health during the court hearing. We recommended in court that the father obtain a psychiatric evaluation and engage in treatment for himself, and with his daughter and her mother. We also recommended that the child not be forced to visit her father until therapeutic interventions could be done. The court upheld the existing visitation and the father was not required to have an evaluation or engage in treatment.

These case histories highlight the following concerns about legal proceedings which may jeopardize the well being of children of divorce. Children are subjected to unreasonable changes in where they live or visitation schedules which would be disruptive to the psychological function of an adult much less a child. Children, who based on medical criteria have been sexually abused, are forced to relate to and be under the authority of the perpetrator without successful therapeutic interventions. An attorney, serving as a guardian ad litem, brings personal issues into the process of making recommendations about custody which reflects sexual bias and a misunderstanding of normal adult behavior. Emotionally disturbed parents are permitted to continue pathological behavior in the interplay with the children without a psychiatric evaluation and treatment, when needed. Parents who are hostile toward each other are allowed to have continued dissension without court ordered therapeutic intervention. Grandparents are given court ordered visitation which adds to the disruption of a child's life and catalyzes the hostility between the parents. The impact of visitation disregards the developmental needs and the presence of diagnosed psychiatric disorders in children.

The allegation of sexual abuse dramatically complicates what is already a very complex issue for children of divorce. It appears at times that the judicial system has an almost reflex response to disregard the allegation of sexual abuse relating to children of divorce. Parents who raise the question by consulting protec-

tive services or medical professionals may be treated as if they are merely trying to manipulate the system. Considering that families who divorce display symptoms of being dysfunctional families, the incidence of sexual abuse occurring in children of divorce is likely higher than the general population. The incidence could be higher in contested divorce cases which likely reflects a greater amount of psychopathology in the divorcing parents. A study conducted by the American Bar Association's Child Advocacy Center and the Association of Family and Conciliation Courts concludes deliberately false allegations of sexual abuse in children of divorce are extremely rare.<sup>1</sup> Two thirds of alleged sexual abuse involving children of divorce were substantiated in another study.<sup>2</sup> It is important to emphasize lack of substantiation does not mean the sexual abuse did not occur. Though clearly the judicial system must be sensitive to frivolous accusations of sexual abuse involving children of divorce, the system must also maintain a very sensitive response ordering definitive therapeutic interventions to help children of divorce who have been victimized. Each case must be carefully evaluated on an individual basis.

Wallerstein<sup>3</sup> reviewed research which has looked at the long term effects of divorce on children. Her paper is summarized and the research referenced in the following paragraphs. Block et al.<sup>4</sup> found after ten years that both parents direct more anger at their sons than their daughters. One of the major areas where conflict between the divorcing parents found continued expression was in disagreement about raising the children.<sup>3</sup> Hetherington<sup>5</sup> found at the time of divorce, which was one to two years after separation, a high irritability between a mother and her children, that a steep decline in parental time and attentiveness had occurred related to the children's needs, there was significant disarray in the household, and that discipline had lapsed or was erratic. The children of divorce, who were four years old when the divorce occurred, showed serious symptomatic behavior when they entered adolescence reflecting both poorly controlled aggression and withdrawal. These children were having difficulties in many domains of their lives as compared to non-divorced families, and were living in families that appeared ill equipped to provide emotional support and guide them during adolescence. Another group showed narcissistic relationships and manipulative behaviors. These children lived with parents who were chronically angry or disturbed. Very few boys were found to be in the group that were doing well in adolescence. All children doing well had a healthy relationship with their mother.<sup>3</sup>

Wallerstein<sup>6</sup> conducted research which found that ten years after the divorce, more than half the children still maintained reconciliation fantasies about their parents and felt that the divorce experience had been the



major formative one of their lives. Although earlier in life the children seemed to be doing well, at ten years many children of divorce appeared to be "troubled, drifting and underachieving . . . Almost all of them confronted issues of love, commitment and marriage with anxiety, sometimes with great concern about betrayal, abandonment and not being loved . . . They continued to have an identification into young adulthood as being a 'child of divorce.' Over half the children from this study emerged as compassionate and competent people . . . based on their own inner resources and the supportive relationship of at least one adult, which was usually their mother. By contrast, almost half of the children were worried, underachieving, self-deprecating and sometimes angry young men and women."<sup>3</sup> Johnston et al.<sup>7</sup> found that the transition between the two parental homes was especially threatening to the children in contested divorce cases. "Parents reported that the children often showed major changes in behavior, including zombie-like reactions and severe withdrawal from which the child seemed unable to rally."<sup>3</sup> Though it was evident that the children were displaying high anxiety that bordered on terror, the children indicated that they still wanted to continue regular visitation with both parents. Four and a half years after divorce, "the children who were in court ordered or shared custody and who had greater access to both homes because of court orders or a mediation decision which overrode the objection of one or sometimes both parents, were significantly more depressed and more withdrawn as compared with peers who were in sole custody, whether it was the mother or the father."<sup>3</sup> The authors state that "most of the evidence for the feasibility of joint custody and frequent continuing contact between parents is based on studies of families that have voluntarily undertaken this arrangement."<sup>7</sup> The article concluded that in divorcing families who contested custody and visitation in the court, joint custody or forced visitation had adversely impacted on the children emotionally.<sup>3</sup>

Buchanan et al.<sup>8</sup> found increases in depression, anxiety and deviant behavior in adolescents with hostile parents four and a half years post separation. Children in dual-residence were particularly affected.<sup>3</sup> Furstenberg et al.<sup>9</sup> concluded "the residential or custodial parent is responsible for child rearing post divorce and that co-parenting appears to be more a myth than a reality."<sup>3</sup> Children who had not seen their fathers in a five year period, compared to those who had seen their father more frequently and recently, were found to be doing better on a range of behavioral and academic measures. This study concluded that there was "no strong evidence that children will benefit from the judicial or legislative interventions that have been designed to promote (non-custodial) parent participation, apart from providing economic support."<sup>9</sup> Guidubaldi

et al.<sup>10</sup> found that children 4 to 6 years after divorce "scored more poorly than those from intact families, on mental indices such as hostility to adults, peer popularity, and symptoms such as night fears and anxieties."<sup>3</sup> Teacher ratings also showed that children of divorce had a greater incidence of dependency, anxiety, aggression, withdrawal, and attention and locus of control problems than children from intact families.<sup>3</sup> Glenn et al.<sup>11</sup> showed an intergenerational problem indicating that "children of divorce are more likely to divorce during their own adulthood than children raised in intact families."<sup>3</sup> Women who had experienced divorce in their childhood experienced divorce and/or separation 60% more than women from intact families whereas it was found to be 35% higher for men. Children of divorce also suffered greater negative consequences than children who had lost a parent due to death during their childhood.<sup>3</sup> Billingham et al.<sup>12</sup> concluded men and women who were children of divorce were more sexually permissive in attitudes but without an ability to make relationship commitments than children from intact families. Young women showed the least permissiveness but at the same time had greater sexual activity which demonstrated a direct conflict between their values and behavior.<sup>3</sup> Wadsworth et al.<sup>13</sup> compared chil-



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dren of divorce to children from intact families in the United Kingdom. Children of divorce as adults were found to be less educated, have higher unemployment, to be more likely single or divorced, and to use more alcohol and cigarettes. The article concludes that divorce is more risky to children than parental death.<sup>13</sup>

Wallerstein concluded in her article that "the earlier view of divorce as a short lived crisis has given way to a more sober appraisal accompanied by rising concerns that a significant number of children will suffer long term and perhaps permanent detrimental effects from divorce, and that other children experience submerged effects that appear years later . . . From the child's perspective, divorce represents an ongoing condition of family life that gives rise to a series of particular experiences and multiple life changes throughout childhood, adolescence and often extending into adulthood."<sup>3</sup> Wallerstein goes on to state that "a frequent finding of these long term studies is the critical importance of the custodial parent/child relationship . . . Another frequent finding in these studies is the detrimental impact of chronic interparental hostility on the child."<sup>3</sup> Wallerstein notes that the parental conflict often derives from and contributes to severe psychopathology in either one or both of the divorcing parents. "The interparental conflict is felt to almost always spill into the parent/child relationship in a way that is detrimental to the child."<sup>3</sup> Wallerstein concludes that "many, perhaps most, children will show responses that arise de novo in subsequent post divorce developmental stages, notably during adolescence and young adulthood, when the psychological and social tasks posed by developmental imperatives tap into earlier divorce related experiences."<sup>3</sup> She recommends that "it is especially important that future research gives weight to the testimony of the inner world of human experience; in this instance, to the child's experience. The particular feelings, suffering and experiences of the child represent the very essence of what needs to be systematically ordered, understood and addressed at individual, family and society levels."<sup>3</sup> Not only should future research take into account the perspective of children, the judicial system should be very sensitive to the feelings, suffering, experiences and developmental stage of children of divorce as well, in formulating decisions and recommendations. Furthermore, the very dismal and frightening outcome that is being found in children of divorce must be addressed, or up to one third of the population of future adults is at risk to suffer severe adverse consequences from this childhood trauma.

It is important to reemphasize that divorcing parents who destructively contest custody and visitation in court are a select group of the divorcing population

who are manifesting indicators of their own psychological struggle with conflict resolution, control and feelings management. The legal system, which is an adversarial system, provides an ideal forum for these parents to act out their psychological problems that particularly relates to their inability to deal with conflict in their lives. The previously mentioned studies which looked at children of divorce did not just select the population who continued to carry conflict into the divorce and acted it out in the legal system. Thus the group of parents in destructively contested divorces represents a much more potentially disturbed group of either one or both parents than would be expected in the general population of divorcing families. Since the outcome for all children of divorce is very worrisome in general, the outcome for children in this select population may put them in a position in which they have little hope unless special measures are in place to address the psychopathology of the divorcing parents.

There is an urgent need for the judicial system in Arkansas to establish a separate court system to address the contested divorces that involve children, as has occurred in other states. For this to be successful, there will have to be an interplay between the legal and medical systems that works in a truly collaborative fashion and focuses on the best interest of the children. In contested divorces, children will need to have their own advocate who will have to be trained to truly maintain a focus on the best interest of the child. Judges will have to educate themselves in what is needed to ensure the well being of children of divorce, including how to utilize expert testimony. Judges must recognize merely ordering a child of divorce to have a healthy relationship with a parent works no better than ordering divorcing parents to restore a healthy marriage. Behavioral experts must maintain a careful awareness of how to evaluate children of divorce and make appropriate recommendations that will serve the children's future well being.

Primary care physicians should closely monitor children of divorce for evidence of psychological problems. Symptoms can be diverse varying from classical or atypical depression to school problems or vague somatic complaints. Problems may arise during the time of separation and divorce, or many years later. Physicians should also be willing to contest decisions of courts which do not serve the best interest of children of divorce, and advocate for a separate court system to serve their special needs. If children from Arkansas who have to go through the trauma of the divorce of their parents are going to be served by the legal system to do well in their future lives, then the judicial system in Arkansas is going to have to develop a system that truly will meet the best interest of children in divorce proceedings.



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Kathleen M. Roman\*

Nowhere has technology been more a boon to mankind than in the area of medical products. Increasingly reliant on tests, procedures and equipment that were non-existent a generation ago, hospitals have led the way in dealing with issues of liability incurred as the result of the utilization of sophisticated technologies. Forced by the threat of product liability, and spurred along by an ever-increasing array of government mandates, most hospitals have developed procedures for purchasing, training, maintaining, repairing and improving the technological advancements they incorporate into services they provide their patients. The benefits of some of these safety standards are becoming evident in physicians' practices as well.

But it is important that doctors and their staffs maintain a vigilant attitude about the possibility of medical malpractice allegations that could arise as a result of the introduction of technological advancements into a practice without benefit of risk management procedures.

**Computers:** In a state that mandates the confidentiality of minors' medical records for diagnoses such as pregnancy and STDs, one doctor's office purchased an expensive billing software program that saved time, increased efficiency of the billing process and flagged bills that exceeded the payment due date. It also provided a copy of the complaint, diagnosis and treatment provided to the patient. Unfortunately, the software package did not provide, and no one in the office discovered it until too late, a means of eliminating treatment information from the charges of minors who fell within the protected classification—even

though their parents continued to be responsible for their medical expenses.

So, the sixteen-year-old was notified that she was pregnant, a fact that she did not want to share with her parents. Unfortunately, the computerized billing program didn't know that, so the grandparents-to-be were informed of the pregnancy via the medical bill. Violation of confidentiality and doctor-patient relationship. And a payment was made on the doctor's behalf rather than try to defend an indefensible mistake.

Many physicians are considering switching to computerized records. As yet, there is only a small amount of case law providing for legal consideration of protecting and validating records. Two concerns are obvious.

First, doctors must assure that records cannot be erased. Software that might allow the disappearance of a patient's record because of an electrical storm would obviously expose a doctor to the potential for serious allegations. If the doctor can't even keep his records straight, a jury may infer, well, he probably didn't provide proper care for the patient either. One court has recommended that all computerized records must be generated as hard copy on a daily basis *and* that the toner or ink used by the printer must be able to be chemically age tested—so the records can be validated in court. This, of course, puts the doctor in the position of maintaining two separate sets of records, a complicating rather than simplifying process.

Second, technologies that allow one written entry with future references to the entry limited to read only, are currently available. Some clinics and office practices have been suspicious of this technology for fear that its defenses might fall prey to a motivated hacker, namely, the defendant in a serious suit or an irate employee with a grudge.

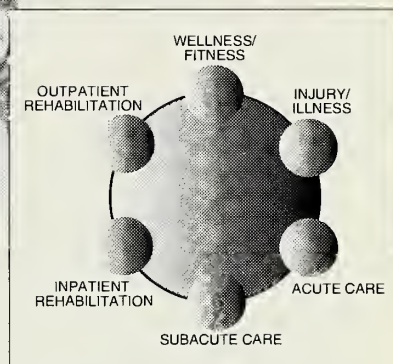
\* Kathleen M. Roman is Director, Risk Management for The Medical Protective Company, Fort Wayne, Indiana.



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In some parts of the country doctors are signing lease agreements with vendors who deliver expensive machinery to the doctor's office on a by-the-day arrangement. In some instances a trained technician accompanies the equipment, with the understanding that the technician should ascertain that the equipment is properly checked, cleaned, calibrated, etc. between uses. This service has proven useful to doctors in rural areas who want to avoid lengthy driving distances for themselves and for their patients. But doctors need to know that they are now assuming risk responsibility for machinery malfunction that would otherwise be covered by a hospital. It is in the doctor's best interest to ensure that legal responsibility for this type of machinery remains with the manufacturer or vendor, and not with the doctor.

**Telephones and FAX machines:** Doctors need to be scrupulous in protecting the privacy of their patients. Car telephones, for example, have the potential to disseminate confidential patient information. Car telephones are assigned a special frequency of the air wave spectrum, and these channels can be picked up by short wave radio receivers. Car phones should be used only to establish a basic topic, the reason for the call. Doctor and patient can then decide on a mutually agreeable time for a future call, to tell a patient if they should schedule an appointment, meet the doctor somewhere, or go to the emergency room. Any topic that could, under the wildest interpretation, be considered confidential should be deferred to a further conversation. It's perfectly acceptable for a doctor to tell the patient, "I'm on my car phone and I'd like to talk with you when we can have a more private line. When can you be available for a call later today?"

FAX machines are best used only for providing emergency life-saving information. Any other kinds of records do not require the speed or expense of faxing and should be mailed (following a signed release from the patient). Murphy's law prevails and a fax gone astray could prove embarrassing and inflammatory for a patient—and could result in a trip to an attorney's office.

New technologies advance the potential for patient care, but doctors must assess the risk that may accrue to themselves—and establish adequate means of addressing the risks.



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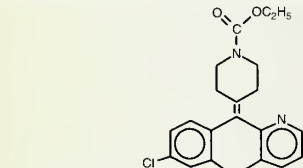


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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

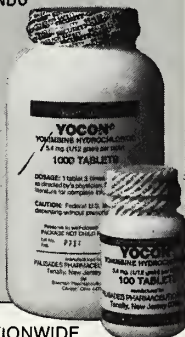
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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# Essential Tremor: An Overview

W. Steven Metzger, M.D.\*

## Abstract

Essential tremor (ET) is typically 4 to 12 Hz frequency, absent at rest, maximal during maintenance of a posture, attenuated during movement and often accentuated at the termination of movement. Prevalence in Americans is 300 to 415 per 100,000 population, and it is frequently disabling. There is controversy about the central or peripheral origin of ET. There is no specific diagnostic test for ET; the diagnosis is made clinically. Ethanol is the most effective suppressor of ET. Treatment is with  $\beta$ -adrenergic blockers, primidone, and benzodiazepines.

The first systematic description of essential tremor (ET) was 100 years ago by Dana in 1887, who regarded the disorder as a hereditary tremor that was a form of "motor neurosis." Most subsequent contributions to the English literature consisted predominately of case reports until Critchley's exhaustive survey of the subject in 1949.<sup>1</sup> The disorder has been variously termed essential, benign essential, hereditary, familial, idiopathic, juvenile, presenile or senile tremor.<sup>1,2</sup>

## PHENOMENOLOGY

The tremor is characteristically of 4 to 12 Hz frequency, with variable amplitude,<sup>1</sup> most commonly due to reciprocal activation of antagonistic muscles, although periods of imbalanced co-contraction may be observed.<sup>3</sup> The frequency of tremor affecting different individuals is quite variable, and there is overlap with the characteristic frequencies of physiological and parkinsonian tremors. This has led to the observation that frequency cannot be the sole criterion by which ET may be distinguished.<sup>2</sup> Essential tremor is typically

absent at rest, maximal during maintenance of a posture, attenuated during movement and often accentuated at the termination of movement.<sup>1,3</sup> It is present at rest only in the occasional patient; differentiation from parkinsonism can be difficult in these individuals. The upper extremities, head and voice are commonly affected, often with asymmetrical limb involvement. Essential tremor has classically been considered to be a monosymptomatic disorder, with rigidity, bradykinesia and postural instability typically being absent. Mild rigidity may be present in some patients.<sup>3</sup>

Marsden describes four types of ET (Table 1). The first is a fast (8-10 Hz), fine postural tremor similar to enhanced physiological tremor. The second, classical ET, is a postural tremor of slower frequency and greater amplitude than physiological tremor. The third is phenomenologically the same as the second, but disabling in degree. The fourth type is termed symptomatic ET, being associated with other neurological disorders, such as polyneuropathy and dystonia.<sup>4</sup> It should be pointed out that the word 'benign' which is often used to describe this condition is somewhat misleading. Many patients are physically and socially handicapped by ET, and some are totally disabled.<sup>1,3</sup>

The relationship between parkinsonism and essential tremor has been investigated, with 2% to 19% of ET patients reportedly also having parkinsonism. Approximately 10% of patients with idiopathic parkinsonism have a family history of ET. However, it has been asserted by one prominent reviewer that there is no convincing evidence of an association between ET and parkinsonism.<sup>5</sup> The relationship certainly seems to be unclear.

## EPIDEMIOLOGY

Essential tremor occurs in all parts of the world. The highest prevalence rates have been observed in Sweden and Finland.<sup>5</sup> Recent surveys in the United States have resulted in an estimated prevalence in

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Americans of 300 to 415 per 100,000 population.<sup>6</sup> For all groups, incidence is noted to increase with advancing age with onset most common after age 40,<sup>5,6</sup> although there is considerable variation in age of onset and severity. A recent epidemiological study in the United States found ET to be more prevalent in women than men and more prevalent in caucasians than blacks.<sup>6</sup>

The hereditary nature of ET has been recognized for at least 100 years. Critchley noted in 1949 that sporadic cases occur, but there is clearly a strong genetic determinant in the condition, with an autosomal dominant mode of transmission being most common. In various series, ET has been found to be familial in 18% to 72% of cases. It is generally accepted that up to 35% to 50% of cases of ET are familial.<sup>1,3,7</sup>

## **PATHOPHYSIOLOGY**

The pathogenesis of ET is currently unknown. No structural abnormality has so far been identified in the brain of essential tremor patients. Current theories have derived from knowledge of the anatomical basis of other tremors, physiological investigations of ET, response of ET to various pharmacological agents and animal models of tremor.

### **Physiological Investigations**

Tremor is the result of complex interactions between the mechanical properties of the limb, segmental and suprasegmental reflex mechanisms, and central oscillators. Volitional movement results from asynchronous muscle group contractions. Synchronization and tremor result from alternating bursts or imbalanced co-activation of agonist-antagonist pairs.

There is controversy about the central or peripheral origin of ET. Physiological tremor is believed to be due to instability and oscillation of the servomechanism associated with the spinal reflex loop. Parkinsonian tremor is believed to be driven by a central (basal ganglia) oscillator. Similar to physiological tremor, which is believed to probably originate primarily in peripheral reflex loop oscillations, some essential tremors can be reset by external perturbations.<sup>4,7</sup>

### **Neuropharmacological Investigations**

A great deal of attention has been given to the attenuating effect of various  $\beta$ -adrenergic blocking agents on ET, with most evidence suggesting that an effect on peripheral  $\beta_2$  adrenoceptors in skeletal muscle is probably most important,<sup>7-10</sup> similar to the effect of  $\beta$ -blockers on physiological tremor.<sup>4</sup> Intravenous and intra-arterial epinephrine enhance the amplitude of physiological tremor, mediated by peripheral  $\beta$ -adrenoceptors in the forearm. This tremorgenic effect is attenuated by propranolol.  $\beta_2$  receptors are located on both intrafusal and extrafusal muscle fibers. However, there is also evidence that  $\beta$ -blockers may

exert an effect on central pathways important in the attenuation of essential tremor, and the therapeutic effects of ethanol, primidone and phenobarbital on essential tremor are most probably exerted via central pathways.<sup>7</sup>

**Table 1**  
Marsden's clinical diagnostic criteria  
for essential tremor.

- 1) absent at rest
- 2) present on maintaining a posture
- 3) not made strikingly worse by movement
- 4) not associated with signs of parkinsonism or cerebellar disease
- 5) suppressed by ethanol - optional.

**Table 2**  
Marsden's subclassifications of  
essential tremor.

- 1) Enhanced physiological tremor
- 2) Classical "benign" ET
- 3) Severe ET
- 4) ET associated with other neurological disorders

### **Harmaline Tremor Model**

In intact monkeys, harmaline produces enhanced physiological tremor. A tremor similar to ET can be induced in monkeys with a combination of harmaline and lesions in the dentate nucleus or ventral tegmentum of the mesencephalon.<sup>7</sup> This tremor persists following curarization or dorsal root section, indicating that it is a centrally originating oscillation. The effect of  $\beta$ -blockers on harmaline tremor has never been studied.

These and other observations have collectively led to a model of three interconnected oscillatory loops in the nervous system important in the genesis of tremor: a spinal reflex loop, an olivocerebellorubral loop and a basal ganglia-thalamocortical loop:

- 1) spinal reflex loop  $\rightarrow$  oscillations  $\rightarrow$  physiological tremor



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- 2) olivocerebellorubral loop → oscillations → ET
- 3) thalamocortical system (basal ganglia) → oscillations → parkinsonian tremor.

## DIAGNOSIS

There is no specific diagnostic test for ET; the diagnosis is made clinically. The first step is to identify a rhythmical tremor as being the movement disorder present. Then the tremor is classified as primarily postural, with other conditions being excluded by examination. All tremor patients should be asked about the effect of ethanol on their tremor. Any condition that enhances physiological tremor should be excluded.<sup>1</sup> Marsden subclassifies ET into four categories (Table 2).<sup>4</sup> Chronic anxiety and depression are important and common concomitant disorders that may require treatment.<sup>1</sup> Over 50% of ET patients see more than one physician before correct diagnosis, and 33% are incorrectly diagnosed initially, usually as having parkinsonism.<sup>1</sup>

## TREATMENT

ET can be difficult to treat. As many as 75% of ET patients consider themselves significantly disabled.<sup>1</sup> In one study, only 55% of ET patients were satisfied with their response to medication, compared to 84% of parkinsonian patients.<sup>1</sup>

Ethanol is the most effective suppressor of ET. There is controversy regarding an increased incidence of alcohol abuse among ET patients. Chronic treatment with ethanol is clearly not practical.

B-adrenergic blockers are the treatment of choice; propranolol and metoprolol are most commonly used. Response is variable. Side effects include fatigue, depression, bradycardia, hypotension, diarrhea and nausea. Blood dyscrasias are uncommon. Contraindications include drug allergy, bradyarrhythmias, asthma, congestive heart failure and diabetes mellitus. The dose is titrated to tolerance.

Primidone and phenobarbital are effective in many patients, and primidone may actually attenuate the amplitude of tremor more than propranolol. Some investigators have found primidone, but not phenobarbital, to be effective. ET patients are usually extremely sensitive to the sedative effects of primidone; start with a low dose (25-50 mg/day). It is doubtful that very large doses are more efficacious than relatively low doses (< 150 mg/day). Some patients may respond better to a combination of propranolol and primidone than either drug alone.<sup>11</sup>

Of the benzodiazepines, alprazolam has recently been demonstrated to attenuate ET. It may be particularly useful for patients requiring occasional, sporadic therapy.<sup>12</sup> The potential for dependence should be taken into consideration. Clonazepam can also be beneficial.

Thymoxamine is currently an experimental agent. It is poorly absorbed orally, and not yet available in America.

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# Computer Disc Revolution

Robert H. Nunnally, M.D.\*

A quiet revolution is occurring in America. Participants range from grade schools to country doctors. For the first time almost anyone with a computer and a telephone can draw on the largest library in the country via modem. While this access to the information highway is surely marvelous, an even more practical technology has appeared.

A single hard disc using the acronym CD-ROM, which stands for Computer Disc-Read Only Memory, has emerged. While the usual recording depends on magnetic tapes or discs, this technology depends on a code etched in a polycarbonate disc which is "read" by a laser beam that relays a binary digital data stream to the computer.

While computer discs, soft or hard, have been around a long time, CD-ROM now makes it possible to store up to 400,000 pages of printed material on a single disc. This capacity means that six or eight CD-ROM discs can carry more information than a 1,000 volume medical library.

In the past, those rural physicians fortunate enough to have access to a medical library found literature review consisted of three stages. One had to look in the indices to find pertinent articles. Next, one had to submit the list to the librarian to see which periodicals were actually available. Then, one ordered those items that the library did not have. Unless one were employed at an academic center, this was a very perplexing and time consuming experience.

Now one can place a CD-ROM disc of six years of the *New England Journal of Medicine* (NEJM), for ex-

ample, in a CD-ROM drive and, with the aid of an operating system called Disc Passage, scan for a word, title or subject. The computer will research and indicate the number of articles found. One punch of a button brings the list of titles. A title can be selected and, by a second push of a button, the text is before you on the screen. Another utility button will operate the printer, and a hard copy is in one's hands in a minute or two. The articles have their own bibliographies.

One of the factors that has produced apprehension about the use of a computer has been the lack of typing or keyboarding skills. Many of us have lived a lifetime without bothering to obtain such skills.

Now, as it turns out, no typing or at least no more than a word or two are required. Our hardware is of a variety of brands but consisting of a 486 chip, 4 RAM expandable to 12 RAM CACHE, operating at 33 MHz with a 230 MB hard drive along with a super Vega color monitor.

This system is PC compatible and uses a Windows operating system.

The CD-ROM drive will limit the speed that the computer can work and may cause problems with computers above 33 MHz.<sup>2</sup>

The CD-ROM drive is accessed through a logo on the Windows screen. Since only one CD-ROM drive is available and therefore the CD-ROM discs must be changed to change journals, only the NEJM logo appears on the Windows display.

Since all our CD-ROM journals use the same search utility, Disc Passage, simply changing discs changes the journal. Of course, any number of CD-ROM drives can be set up.

While the medical literature is vast and even the indices are formidable, that portion that pertains to a given problem is less intimidating. Our library consists of six journals concerning the type of family practice that we do.

An added bonus of being able to print out the en-

---

\* Robert H. Nunnally, BSM, M.D., is a family physician with the Ouachita Clinic in Camden, Arkansas. He is a board certified family physician, a Fellow of the American Academy of Family Physicians, and was a charter diplomate of the American Board of Family Practice.

tire articles and their bibliographies is that the latter gives us access to other references that might be obtained through *Grateful Med* and the National Library of Medicine (abstracts) or other services such as BRS Colleague.

Several of the journals on CD-ROM are updated every six months as is the *New England Journal of Medicine*. For most of us in primary care, six months from the leading edge of publication is close enough.

Over the years many of us have read two to three journals each week. However, when a problem arose the first source of information was usually a textbook or therapeutic manual such as *Current Therapy*. Now one can search relevant journals via CD-ROM and a search utility such as Disc Passage in seconds.

CD-ROM discs on medical subjects are available from the following suppliers:

AMA, P.O. Box 109050, Chicago, IL 60610-9050

AAFP, 8880 Ward Parkway, Kansas City, MO 64114-2797

Creative Multimedia Corporation, 514 NW 11th Avenue  
Suite 203, Portland, OR 97209

Continuing Medical Education Associates, 4015  
Hancock St., Suite 120, San Diego, CA 92110

### Summary

CD-ROM Computer Discs with read only memory are etched in polycarbonate discs that permit storage of up to 400,000 pages on a single disc. Use of this technology supplemented by access to the National Library of Medicine or a large information service brings the medical library to the rural physician's office. This allows pertinent journal information to be applied to day-to-day office practice.

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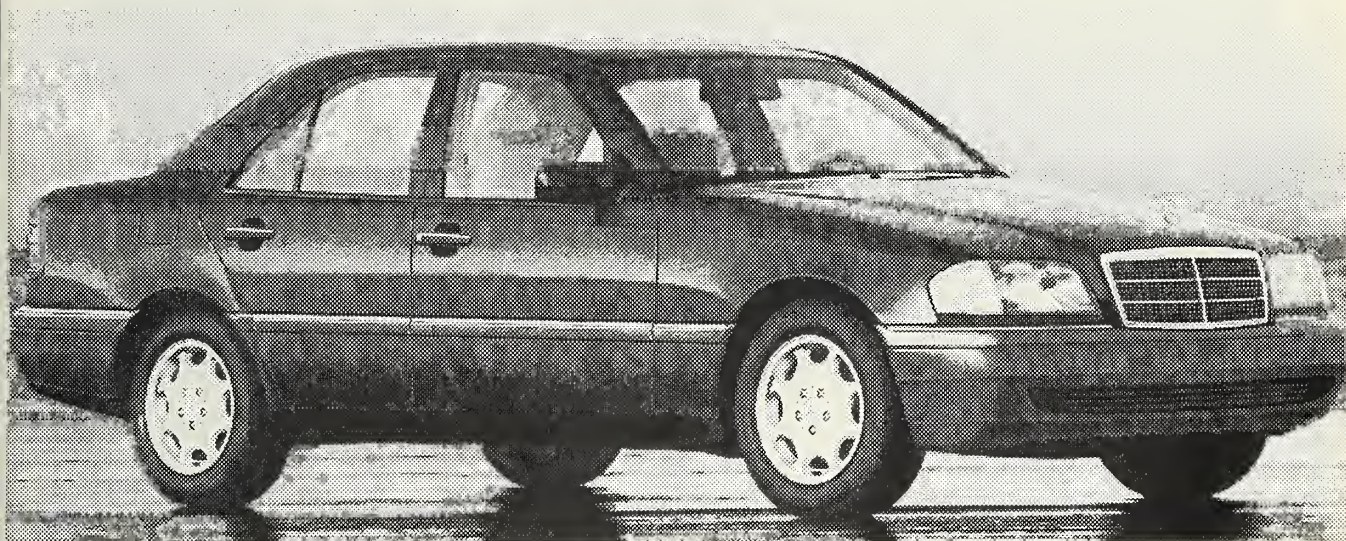




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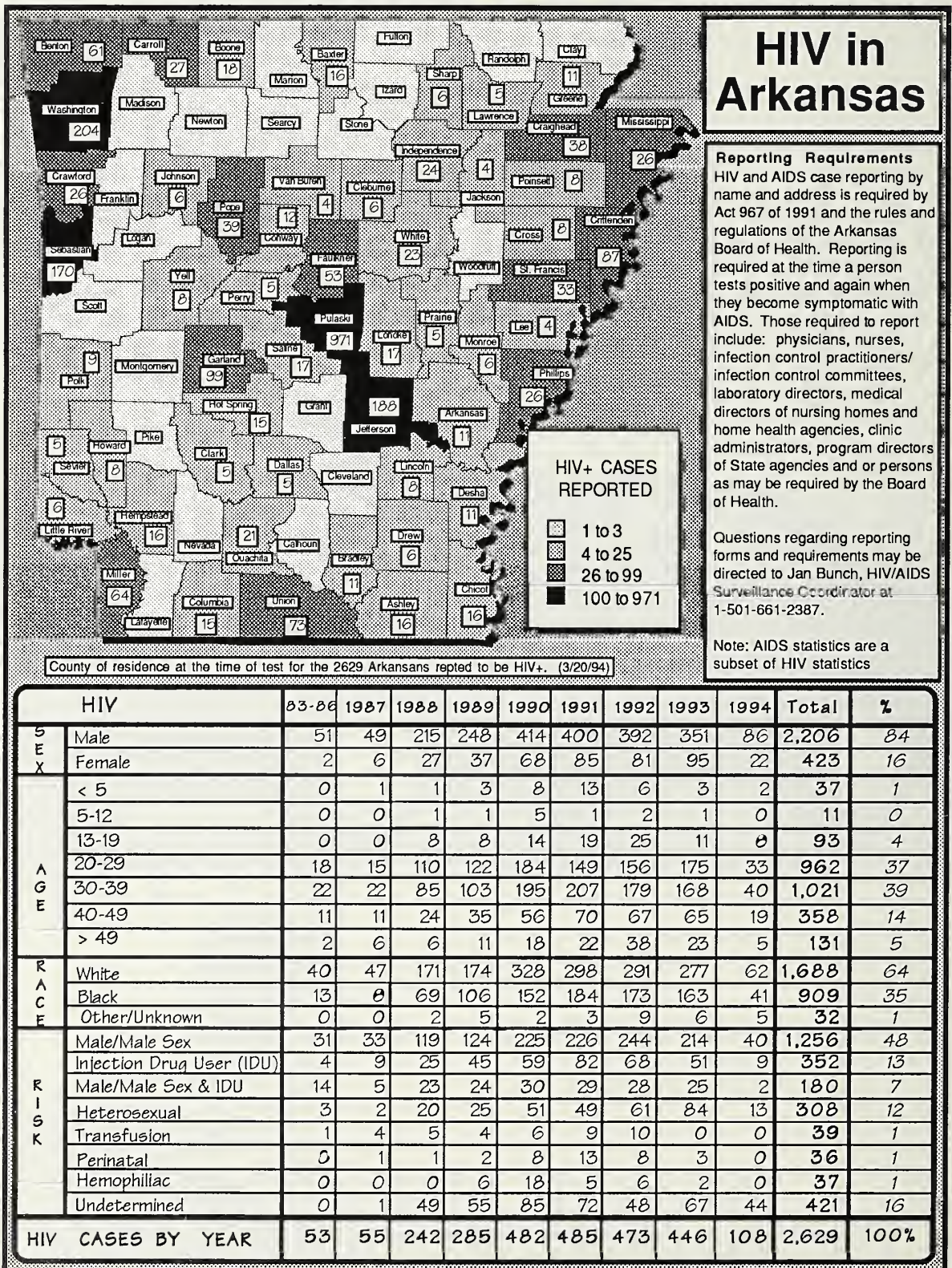
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# Arkansas HIV/AIDS Report

## 1983-1994



Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1994

### AIDS in Arkansas

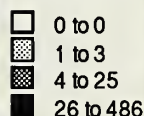
#### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Act 967 of 1991 and the rules and regulations of the Arkansas Board of Health. Reporting is required at the time a person tests positive and again when they become symptomatic with AIDS. Those required to report include: physicians, nurses, infection control practitioners/infection control committees, laboratory directors, medical directors of nursing homes and home health agencies, clinic administrators, program directors of State agencies and or persons as may be required by the Board of Health.

Questions regarding reporting forms and requirements may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator at 1-501-661-2387.

Note: AIDS statistics are a subset of HIV statistics

#### AIDS CASES REPORTED



Of the 2629 Arkansans reported to be HIV+, 1396 have been diagnosed with AIDS. (3/20/94)

AIDS		83-86	1987	1988	1989	1990	1991	1992	1993	1994	Total	%
SEX	Male	39	46	77	70	170	176	250	336	54	1,218	87
	Female	1	4	6	10	20	25	35	64	13	178	13
AGE	< 5	0	0	1	1	6	6	3	2	0	19	1
	5-12	0	0	1	0	1	1	0	1	0	4	0
	13-19	0	0	0	0	4	3	2	4	2	19	1
	20-29	16	15	27	24	55	57	81	110	9	394	28
	30-39	16	23	36	41	78	80	128	178	35	615	44
	40-49	7	8	10	7	35	41	52	78	17	255	18
	> 49	1	4	8	7	11	13	19	27	4	94	7
RACE	White	31	43	61	58	141	134	206	275	37	986	71
	Black	9	7	20	21	47	66	75	121	30	396	28
	Other/Unknown	0	0	2	1	2	1	4	4	0	14	1
RISK	Male/Male Sex	24	31	59	50	120	120	179	224	40	847	61
	Injection Drug User (IDU)	2	10	4	11	18	29	44	66	10	194	14
	Male/Male Sex & IDU	12	4	6	6	18	17	19	25	4	111	8
	Heterosexual	2	3	3	7	11	11	25	50	8	120	9
	Transfusion	0	2	7	3	7	11	3	2	0	35	3
	Perinatal	0	0	1	1	6	6	3	3	0	20	1
	Hemophiliac	0	0	1	1	5	5	4	5	0	21	2
	Undetermined	0	0	2	1	5	2	8	25	5	48	3
AIDS CASES BY YEAR		40	50	83	80	190	201	285	400	67	1,396	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



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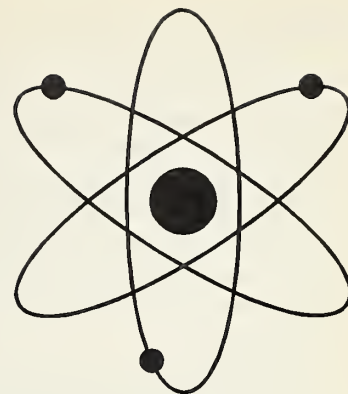
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# Radiological Case of the Month



Steven R. Nokes, M.D.  
Scott B. Harter, M.D.

## Diagnosis of Carotid Artery Stenosis: Comparison of MR Angiography with Contrast Angiography

Recent reports from several institutions have described the use of magnetic resonance (MR) angiography in evaluating the carotid bifurcation.<sup>1-6</sup> We compared MR angiography and x-ray angiography of the carotid bifurcation in twenty-five patients to determine the accuracy of this new technique outside of major teaching institutions.



*Figure 1a & b (top): Grade 0 lesion in a 59-year-old patient with a visual field defect. MR angiogram (a) and a conventional angiogram (b) are normal.*

*Figure 2a & b (bottom): Normal MR (a) and conventional (b) angiogram of the carotid bifurcation in the same patient as figure 1.*



*Figure 3a & b (top): 57-year-old patient evaluated for transient ischemic attacks. MR angiogram (a) was read as mild stenosis due to loss of signal from complex flow in the carotid bulb (arrow). The conventional angiogram (b) is normal.*

*Figure 4a & b (bottom): Grade 1 lesion in a 60-year-old patient with transient ischemic attacks. The MR angiogram (a) and conventional angiogram (b) reveal 40% stenosis of the internal carotid artery (arrow).*

## Patients and Methods:

Twenty-five patients undergoing four vessel angiography using conventional film between March and July of 1993 had MR angiograms for comparison. Eighteen (72%) of the exams were performed on the same day; five (20%) within four days, and two (8%) within two months (12 days and 48 days). The study group included 13 females (52%) and 12 males (58%), the average age was 64 (range 23-84).

MR angiograms were performed with a 1.5 T Signa MR System (GE Medical Systems, Milwaukee) using a two-dimensional, time-of-flight (2D, TOF) technique with maximum intensity pixel (MIP) reconstruction.<sup>6,7</sup> Contiguous 1.5 mm axial sections were obtained using a gradient-echo pulse sequence. Contrast between vessels and stationary tissue is based on flow related enhancement (no dye is injected). The pulse sequence employs a radio frequency spoiling pulse to minimize stationary signal. First order gradient moment nulling provides constant velocity flow compensation.

In all cases, 80 sections were obtained resulting in 12 cm of coverage. A repetition time (TR) of 45 msec and a flip angle of 60° were employed. The echo time (TE) was 8.7 msec. One excitation at each of 128 phase encoding steps was provided, with 256 frequency encoding steps. A 20 cm field of view resulted in an in plane resolution of 0.76 x 1.56 mm. Imaging time was eight minutes three seconds.

The axial images thus acquired were used as source data for the construction of projection images using an MIP technique on the standard GE workstation. Each carotid and vertebral artery was separately reprojected to eliminate overlap of vessels. Eighteen projections at 10° increments over a 180° range were filmed. The MR and conventional angiograms were scored according to a standardized scoring system for diameter narrowing of the internal carotid artery (Table 1). The MR examinations were read blindly by one of the authors (SBH). The conventional angiograms were read prospectively by the angiographer performing the study and serve as the gold standard.

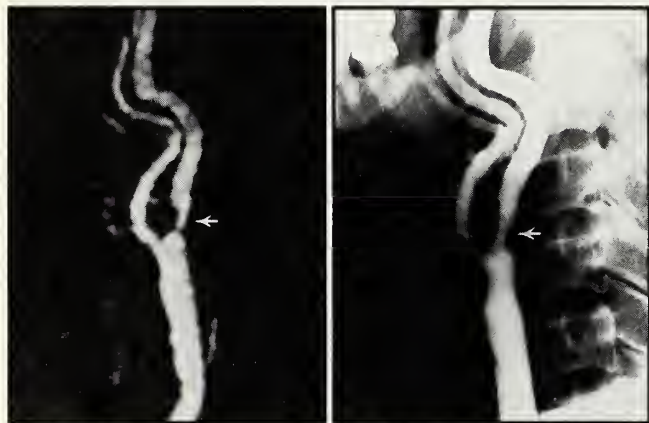


Figure 5a & b: Grade 2 lesion of the internal carotid artery in this 71-year-old patient with transient weakness. MR angiography (a) and conventional angiography (b) demonstrate a 60% stenosis of the proximal internal carotid (arrows).



Figure 6a & b: Grade 3 lesion of the origin of the internal carotid artery in this 60-year-old patient with leg weakness. The MR angiogram (a) and conventional angiogram (b) reveal 90% stenosis (arrow).

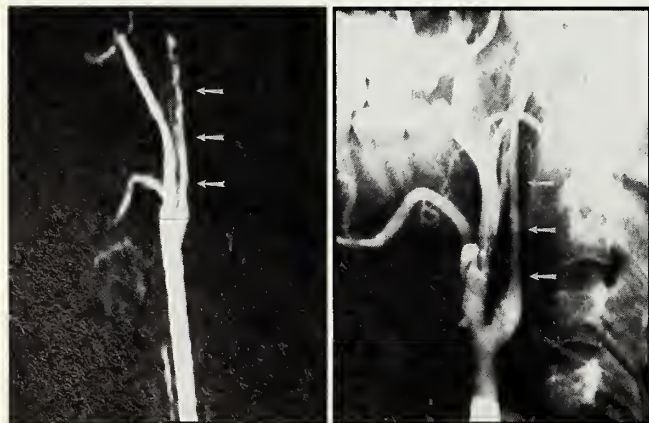


Figure 7a & b: Grade 3 lesion in a 23-year-old patient with right sided headaches. The MR (a) and conventional (b) angiograms demonstrate a dissection (arrows) of the internal carotid artery with smooth tapering of the vessel. Fibromuscular dysplasia was seen on both exams superiorly.

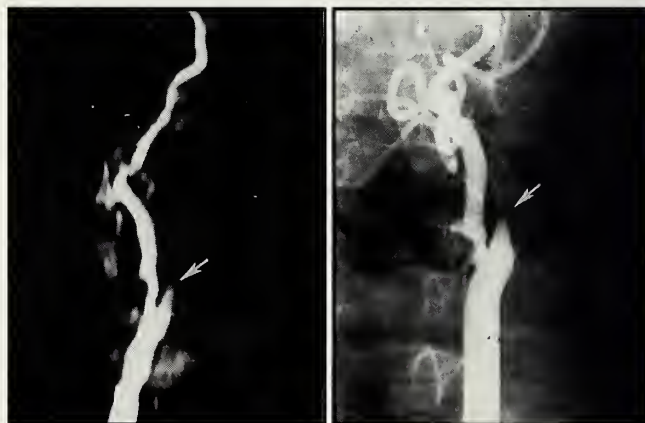


Figure 8a & b: Grade 4 lesion (complete occlusion) of the internal carotid artery (arrow) in this 79-year-old patient is demonstrated by both MR angiography (a) and conventional angiography (b). The external carotid artery is patent.



Table 1

SCORING SYSTEM FOR MR AND CONVENTIONAL ANGIOGRAMS		
DIAMETER NARROWING (%)	GRADE	DEGREE OF STENOSIS
0-15	0	Normal
16-49	1	Mild
50-69	2	Moderate
70-99	3	Severe
100	4	Occluded

Table 2. Correlation of MR and conventional angiography in 50 carotid arteries in 25 patients.

CONTRAST ANGIOGRAPHY					
MR Angiography	Normal	Mild	Moderate	Severe	Occluded
Normal	24				
Mild	3	5			
Moderate			6		
Severe				8	
Occluded					3

Shaded Boxes Indicate Concordant Exams

## Results:

There was 95% overall agreement between MR angiography and conventional angiography (Table 2). Twenty-seven carotids (54%) were normal by angiography (Figures 1 & 2). MR overestimated three of these by one grade due to flow artifact in the bulb (Figure 3). There was agreement between the two techniques in the remaining twenty-three (46%) cases including five (10%) cases with mild narrowing (Figure 4), six (12%) cases with moderate narrowing (Figure 5), eight (15%) cases with severe stenosis (Figures 6 & 7) and three (6%) cases of complete occlusion (Figure 8).

## Discussion:

Cerebrovascular disease is the third leading cause of death in the U.S. and atherosclerotic carotid artery disease is an important etiological factor in most strokes.<sup>7</sup> The recent NASCET study demonstrated a significant reduction in the risk of stroke in patients with symptomatic stenosis of the carotid artery measuring greater than 70% who underwent carotid endarterectomy.<sup>8</sup> With the availability and efficacy of medical and surgical treatments for atherosclerotic carotid artery disease, it is important to accurately demonstrate these lesions with a minimum of morbidity.

Conventional selective carotid angiography remains the gold standard for diagnosing carotid artery disease, but entails a small but significant risk. The risk of minor neurological events ranges from 1.3 to 4.5% and the risk of permanent deficit or stroke has been estimated to range from 0.6 to 1.3%.<sup>9,10</sup> Consequently, accurate noninvasive methods of diagnosing significant stenosis of the cervical carotid artery have been sought.

Duplex and color Doppler ultrasound (US) represent alternative noninvasive modalities for the evaluation of carotid bifurcation stenosis.<sup>11,12</sup> The literature supports both a high sensitivity and specificity, although the technique is operator dependent. Potential disadvantages include a limited window of visualization of the neck vessels,

nonvisualization in the presence of extensive calcified plaques, and relative insensitivity for the discrimination of occlusion and near occlusion. Relative strengths of US include the low cost and portability of the study.

MR angiography performed well in this study and was 100% accurate in discriminating surgical from nonsurgical lesions. It is not affected by factors which may compromise conventional angiography (poor renal function, contrast allergy, coagulopathy, lack of pulses or inability to advance a catheter), or US (tortuous vessels, unfavorable location of lesion, heavy calcifications or immediate post-up from endarterectomy). MR angiography has the further advantage of allowing unlimited viewing orientations retrospectively. It is unsuitable in patients who can not remain motionless for the eight minute acquisition or have surgical clips in the bifurcation regions. Neither US or MRA accurately detect ulcers.

Currently, MR angiography is a sensitive and specific noninvasive means of evaluating the carotid bifurcation. The complete preoperative evaluation of a patient being considered for endarterectomy should include evaluation of the arch origins of the carotid arteries and the intracranial vasculature to exclude tandem lesions. Although uncommon, such lesions could limit the efficacy of carotid endarterectomy. MRA may prove efficacious in evaluating the intracranial circulation, but flow artifacts have hampered its use in the aortic arch.<sup>13,14</sup>

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We would like to thank the following physicians for their help in this study: James Adametz, M.D.; Beverly Beadle, M.D.; Hugh Burnett, M.D.; Thomas Cain, M.D.; Robert Casali, M.D.; Robert Dickins, M.D.; Gordon Gibson, M.D.; James Hazelwood, M.D.; Stephen Holt, M.D.; Zach Mason, M.D.; David Reding, M.D.; Scott Schlesinger, M.D.; and Jan Sullivan, M.D.

Our special thanks to Dorothy Staggs for preparing the manuscript and Cyndi Szarmach for the photography.

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*Authors: Steven R. Nokes, M.D. and Scott B. Harter are with Radiology Consultants of Little Rock.*



**Dr. O.H. Clopton** and **Dr. Stephen Woodruff**, both of Jonesboro, have been named as co-medical directors for the St. Bernard's Regional Medical center Health Associated Regional Providers (SHARP) physician-hospital organization.

As co-medical directors, Clopton and Woodruff will be responsible for the utilization management of SHARP.

**Dr. Leo Drolshagen, III**, Fort Smith, has been named chief of staff at St. Edward Mercy Medical Center for a second one-year term, and **Dr. John Weisse** has been named chief of staff elect.

Dr. Drolshagen is associated with Radiologists P.A., in Fort Smith, and serves as medical director of magnetic resonance imaging at St. Edward. He also serves as an assistant professor at the Arkansas Health Education Center of the University of Arkansas in Fort Smith.

Dr. Weisse has been in private practice in Fort Smith as a surgeon since 1976 and is an assistant clinic professor in the department of surgery at the University of Arkansas. He has served on the St. Edward Board of Advisers and is a former chief of surgery at St. Edward.

**Dr. Harry P. Ward**, chancellor of the University of Arkansas for Medical Sciences, has been elected chairman of the board of the Association of Academic Health Centers, a nonprofit organization of more than 100 academic health centers in the United States and Canada.

As chairman, Dr. Ward will preside over meetings and help direct activities of the organization. He also serves as a professor of medicine on the faculty of UAMS.

### Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the month of March are:

James W. Campbell	Little Rock
Robert D. Dickins	Little Rock
Wilbur M. Giles	Little Rock
Steven R. Nokes	Little Rock
Scott M. Schlesinger	Little Rock
Joe M. Tullis	Mountain Home

# In Memoriam

---

### Henry G. Hollenberg, M.D.

Dr. Henry G. Hollenberg, of Little Rock, died Sunday, March 20, 1994. He was 91.

He is survived by his wife, Josephine Heiskell Hollenberg of Little Rock; his son, Henry G. "Fritz" Hollenberg, Jr. of Little Rock; two daughters, Elizabeth Cravens Hollenberg Powers of Fort Smith, Mary Blue Hollenberg White of Little Rock; ten grandchildren, Stacie Hollenberg Reid of Charlottesville, Va., Henry G. Hollenberg, III, M.D. of Shreveport, La., Thomas Tannen Hollenberg of Little Rock, Howison Hollenberg of Atlanta, Ga., Elizabeth Clark White of Little Rock, Rebecca White of Little Rock, Lt. U.S.N. Kyle Everette White of Charleston, S.C., Rachel Chandler Powers Spencer of Brownsville, Tenn., John Dickey Powers of Little Rock, Kathleen Blue Powers Gilton of Houston, Texas; four great-grandchildren; one step-son, Fred H.

Harrison; one step-daughter, Ellen W. Harrison; and four step-grandchildren, Katherine R. Harrison, John R.E. Dickins, Jr., Josephine H. Dickins and F. Heiskell Dickins, all of Little Rock.

### Rufus Charles Shanlever, M.D.

Dr. Rufus Charles Shanlever, of Jonesboro, died Thursday, February 17, 1994. He was 94.

Survivors include his wife, Mary Jane Nisbett Shanlever; three sons, R. Charles Shanlever, Jr. of Crystal Lake, Ill., Dr. W.T. Shanlever of Jonesboro and Dr. Sam R. Shanlever of Mena; one brother, Ralph Shanlever of Clinton, Tenn.; six grandchildren; and five great-grandchildren.

# New Members

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## CAMDEN

**Daniel, William A.**, Internal Medicine. Medical education, Tulane Medical School, New Orleans, 1975. Internship/Residency, Charity of New Orleans, 1978. Board certified.

## CONWAY

**Collins, Mitchell L.**, Oral and Maxillofacial Surgery. Medical education, University of Alabama, Birmingham, 1992. Internship/Residency, University of Alabama, Birmingham, 1994.

## FORREST CITY

**Patton, William C.**, Pediatrics. Medical education, University of Alabama, Birmingham, 1979. Internship/Residency, UT/Le Bonheur Children's Hospital, 1982. Board certified.

## FORT SMITH

**Gardner, Kenneth E.**, Radiation Oncology. Medical education, University of Arkansas for Medical Sciences, Little Rock, 1982. Internship, UAMS, 1983. Residency, University of Florida, 1986. Board certified.

## LITTLE ROCK

**Carle, Scott W.E.**, General Practice. Medical education, University of Arkansas for Medical Sciences, Little Rock, 1984. Internship, AHEC-Fort Smith, 1985. Residency, Arkansas Children's Hospital, 1986.

**Leithiser, Richard E., Jr.**, Pediatric Radiology. Medical education, Bowman-Gray School of Medicine, Winston-Salem, N.C., 1979. Internship/Residency, University of Rochester, New York, 1983. Board certified.

## MOUNTAIN HOME

**Nachtigal, Kent P.**, General Surgery. Medical education, University of South Dakota, Vermillion, 1981. Internship/Residency, Wesley Medical Center, Wichita, Kansas, 1986. Board certified.

**Spore, John M.**, General Surgery. Medical education, University of Kansas, Wichita, 1982. Internship/Residency, Wesley Medical Center, Wichita, Kansas, 1987. Board certified.

## ROGERS

**Johnson, Royce O., II**, Ophthalmology. Medical education, University of Chicago, Pritzker School of Medicine, 1974. Residency, University of Chicago, 1978. Board certified.

## OUT OF STATE

**Charles, Steve T.**, Ophthalmology, Memphis, Tennessee. Medical education, University of Miami School of Medicine, 1969. Internship/Residency, University of Miami School of Medicine, 1973. Board certified.

**Cook, Stephen L.**, Cardiology, Memphis, Tennessee. Medical education, Yale University School of Medicine, New Haven, Conn., 1983. Internship/Residency, University of California, San Francisco, 1986. Board certified.

**Edwards, Todd D.**, Cardiology, Memphis, Tennessee. Medical education, Hahnemann University School of Medicine, Philadelphia, 1987. Internship/Residency, University of Pittsburgh, 1990. Board certified.

**Flanagan, William H.**, Internal Medicine/Cardiology, Memphis, Tennessee. Medical education, University of Arkansas for Medical Sciences, Little Rock, 1970.. Internship, University Hospital, Little Rock, 1975. Residency, University of Rochester, 1977. Board certified.

**Gubin, Steven S.**, Cardiology, Memphis, Tennessee. Medical education, Internship/Residency, St. Joseph Mercy Hospital, Ann Arbor, Michigan, 1987. Board certified.

**Himmelstein, Stevan I.**, Cardiovascular Disease, Memphis, Tennessee. Medical education, University of Tennessee, Memphis, 1982. Internship/Residency, Duke University Medical Center, 1985. Board certified.

**Holloway, David H.**, Cardiology, Memphis, Tennessee. Medical education, University of Tennessee, Memphis, 1961. Internship/Residency, Duke Hospital, 1966. Board certified.

**Russo, William L.**, Cardiovascular Disease, Memphis, Tennessee. Medical education, University of Tennessee, Memphis, 1970. Internship/Residency, City of Memphis Hospitals, 1974. Board certified.

**Stern, Thomas N.**, Cardiology, Memphis, Tennessee. Medical education, Washington University Medical School, St. Louis, 1948. Internship, St. Louis City Hospital, 1949. Residency, John Gaston Hospital, 1952. Board certified.

**Turner, Jan L.**, Cardiology, Memphis, Tennessee. Medical education, University of Louisville, Kentucky, 1971. Internship/Residency, University of Colorado Affiliated Hospitals, 1974. Board certified.



# Resolution

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## William O. Green, III, M.D.

Whereas, the members of the Pulaski County Medical Society note with sincere sorrow the untimely death of our esteemed colleague, William O. Green, III, M.D.; and

Whereas, his faithful membership in this and many other professional organizations gave evidence of his devotion to his profession; and

Whereas, Dr. Green had earned the respect and admiration of his patients and his peers; be it therefore

*RESOLVED*, that this resolution be adopted and placed in the permanent archives of this Society; and

*RESOLVED*, that a copy be mailed to Dr. Green's family as a token of our sympathy; and

*RESOLVED*, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
March 16, 1994

By Order of the Memorials Committee  
Bruce E. Schratz, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

## William Sexton Lewis, M.D.

Whereas, the membership of the Pulaski County Medical Society is saddened to learn of the death of our respected colleague, William Sexton Lewis, M.D.; and

Whereas, he was a faithful member of this Society for more than thirty years and was held in high esteem by his colleagues for his pioneering work in his chosen specialty of cardiology; and

Whereas, Dr. Lewis' many years of distinguished service to the Arkansas chapter of the American Heart Association was evidence of the devotion he felt both towards his patients and towards the citizens of this state; be it therefore

*RESOLVED*, that this resolution be adopted and placed in the permanent archives of this Society; and

*RESOLVED*, that a copy be mailed to Dr. Lewis' family as a token of our sincere sympathy; and

*RESOLVED*, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
March 16, 1994

By Order of the Memorials Committee  
Bruce E. Schratz, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

## N. Henry Simpson, Jr., M.D.

Whereas, the members of the Pulaski County Medical Society are saddened by the recent death of a respected member, N. Henry Simpson, Jr., M.D.; and

Whereas, Dr. Simpson was a loyal member of this organization for forty-seven years, giving freely of his time and energy towards its betterment; and

Whereas, he will long be remembered by his colleagues and patients as a skillful and compassionate physician; be it therefore

*RESOLVED*, that this resolution be adopted and filed in the permanent records of the Society; and

*RESOLVED*, that a copy be mailed to Dr. Simpson's family as an expression of our heart-felt sympathy; and

*RESOLVED*, that a copy be forwarded to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
March 16, 1994

By Order of the Memorials Committee  
Bruce E. Schratz, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

# Medicine in the News



*Left: Glen F. Baker, M.D. accepts an award on behalf of the Arkansas Medical Society from Lonnie R. Bristow, M.D., Chair, AMA Board of Trustees at the 1994 National Leadership Conference State Growth Awards. The award was presented for increased membership in 1993.*



*Above: Presidents of state medical societies and AMA leaders stand united in support of health system reform principles during the AMA's March 8 summit in Washington, D.C.*



# Things To Come

## June 3-4

**Apheresis Update 1994.** Stouffer Concourse Hotel, Arlington, Virginia. Sponsored by the American Association of Blood Banks, Society for Hemapheresis Specialists and the American Society for Apheresis. For more information, call (301) 215-6482.

## June 5-10

**3rd Annual New Orleans Anesthesiology Comprehensive Review & Update.** Hyatt Regency, New Orleans. Category I credit: 42 hours. For more information, call (504) 588-5466 or (800) 588-5300.

## June 8-12

**Invasive Surgery: Is It Obsolete? 56th Annual Meeting of the International College of Surgeons-United States Section,** Stouffer Tower City Plaza Hotel, Cleveland, Ohio. For more information, call (312) 787-6274.

## June 9-10

**Treatment Strategies for the Oncology Patient: Expanding Horizons in Transfusion Medicine.** Hyatt Regency, Bethesda, Maryland. Sponsored by the American Association of Blood Banks, the Transfusion Medicine Academic Award Program and the Transfusion Medicine Specialized Center of Research Program of the National Heart, Lung, and Blood Institute. For information, call (301) 215-6482.

## June 9-11

**4th Annual Meeting of the Southern Association for Geriatric Medicine.** Westin Resort, Hilton Head, South Carolina. For more information, call (205) 945-1840.

## June 11-15

**2nd Annual Board Review Course in Family Medicine.** Crystal Gateway Marriott Hotel, Arlington, Virginia. Sponsored by the George Washington University Medical Center, Office of CME. Fee: \$650, physicians. For more information, call (202) 994-4285.

## June 17-18

**National Blood Inventory Management Conference.** Hyatt Orlando, Florida. Sponsored by the American Association of Blood Banks, Florida Association of Blood Banks, the Council of Community Blood Centers and the American Red Cross. For information, call (301) 215-6482.

## June 23-25

**1st Annual Meeting of the Southern Association for Family Practice.** The Woodlands, Williamsburg, Virginia. For more information, call (800) 423-4992.

## July 15-16

**Hand Review '94.** Holiday Inn, Capitol Plaza, Sacramento, Calif. Sponsored by the Office of Continuing Medical Education, UC Davis School of Medicine and Medical Center. For more information, call (916) 734-5390.

## July 16-22

**19th Annual National Wellness Conference.** University of Wisconsin, Stevens Point, Wisconsin. For more information, call (800) 243-8694.

## July 28-30

**7th Annual Meeting of the Southern Association for Oncology.** Jekyll Island Club Hotel, Jekyll Island, Georgia. For more information, call (205) 942-0530.

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## Neurology Update

May 12, 12:00 noon, Medical Center of South Arkansas, Conference Room #3, El Dorado. Sponsored by AHEC South Arkansas and presented by Lee Archer, M.D. Category I credit: 1.0 hour. No fee.

## Deep Vein Thrombosis and Pulmonary Embolism

May 17, 6:30 p.m., Baxter County Regional Hospital Education Building, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Robert Lavender, M.D. No fee; Category I credit: 2.0 hours.

## Perspectives in Pain Management

May 19, Statehouse Convention Center, Little Rock. Sponsored by Arkansas Hospice Association, American Cancer Society and Arkansas Cancer Pain Initiative. For more information, call 664-3480.

## Mammography

May 26, 12:00 noon, Medical Center of South Arkansas (MCSA) Conference Room #3, El Dorado. Sponsored by AHEC South Arkansas and presented by Susan Klimberg, M.D. and David Bourne, M.D. Category I credit: 1.0 hour. No fee.

## Sixteenth Annual Family Practice Intensive Review

June 3-5, time to be announced, UAMS, Little Rock. Sponsored by UAMS and presented by Jerry Mann, M.D. and Mary Lindsey, L.C.S.W.

## Irritable Bowel Syndrome

June 9, 12:00 noon, Medical Center of South Arkansas (MCSA) Conference Room #3, El Dorado. Sponsored by AHEC South Arkansas and presented by Geoffrey Goldsmith, M.D. Category I credit: 1.0 hour. No fee.

## Health Care Ethics Workshop

June 12-17, Little Rock. Presented by the Division of Medical Humanities at the University of Arkansas for Medical Sciences. Fee: \$290. For more information, call Chris Hackler at 661-7970.

## Rheumatology

June 21, 6:30 p.m., Baxter County Regional Hospital Education Building. Sponsored by Baxter County Regional Hospital and presented by Andrew R. Baldassare, M.D. Category I credit: 2.0 hours. No fee.

## Hypertensive Diabetes

June 23, 12:00 noon, MCSA Conference Room #3, El Dorado. Sponsored by AHEC South Arkansas and presented by Alan Garber, M.D. Category I credit: 1.0 hour.

## Thrombotic Disorders

July 14, 12:00 noon, MCSA Conference Room #3, El Dorado. Sponsored by AHEC South Arkansas and presented by John Eidt, M.D. Category I credit: 1.0 hour.

## Hepatitis C

July 28, 12:00 noon, MCSA Conference Room #3, El Dorado. Sponsored by AHEC South Arkansas and presented by Jerry Mann, M.D. Category I credit: 1.0 hour.

## Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

### FAYETTEVILLE-VA MEDICAL CENTER

General Medical Topics, Thursdays, 12:00 noon, Auditorium, Bldg. 3  
Medical Grand Rounds, Thursdays, 12:00 noon, Conference Room, Bldg. 4

### HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, May 27, June 10 & 24, July 8, 12:30 p.m., AMI Ozark - Quapaw Room

### LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom



*Pediatric Grand Rounds*, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
*Pediatric Neuroscience Conference*, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
*Pediatric Pharmacology Conference*, 5th Wednesday, 12:00 noon, 2nd Classroom  
*Pediatric Research Conference*, 1st Thursday, 12:00 noon, 2nd Floor Classroom

#### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Cancer Conferences*, Thursdays, 12:00 noon, location to be announced. Lunch provided.  
*Chest Conference*, 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*General Surgery Grand Rounds*, 1st Thursday, 7:00 a.m. Smith Room. Light breakfast provided.  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided.  
*Journal Club*, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Mental Health Conference*, 3rd Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided.  
*Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided

#### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*Breast Conference*, 3rd Thursday, 7:00 a.m., Conference Room 1  
*GI Conference*, 4th Friday, 11:30 a.m., Conference Room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Category 1 credit available. Lunch provided.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided.  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided.

#### **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Chest & Problems Case Conference*, 3rd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Medicine Conference*, 1st Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*Surgery Conference*, 2nd Wednesday, 12:00 noon, Assembly room. Lunch provided.  
*X-ray Case Conference*, 4th Wednesday, 12:00 noon, Assembly room. Lunch provided.

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

#### **LITTLE ROCK-UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Family Practice Grand Rounds*, Tuesdays, 12:15 p.m., Family Practice Center, 6th and Elm  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month

*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS Jones Eye Institute, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Jones Eye Institute  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Journal Club*, once a month, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, 4th Thursday, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Pre-op/Didactic Conference*, Mondays, 5:00 p.m., VAMC-LR, 4D  
*Urology Radiology Conference*, 1st Thursday, 5:00 p.m., UAMS, Radiology Department  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Urology VA Teaching Rounds*, every Friday, 7:30 a.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GRECC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

#### **EL DORADO-AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Dermatology Conference*, 1st Tuesdays and 1st Thursdays, AHEC - South Arkansas  
*GYN Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas



*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Pediatric Case Presentation*, 3rd Tuesday, 3rd Friday, AHEC - South Arkansas  
*Pediatric Grand Rounds*, every Tuesdays, 8:00 a.m., AHEC - South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC - South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC - South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC - South Arkansas

#### **FAYETTEVILLE-AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center  
*Medical/Surgical Conference Series*, 4th Tuesday, 12:30, Bates Medical Center, Bentonville  
*Primary Care Conferences*, 1st & 3rd Mondays, 12:00, every Tuesday 7:30 a.m., Washington Regional Medical Center

#### **FORT SMITH-AHEC**

*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 1st Tuesday, 11:30 a.m., Sparks Regional Medical Center  
*Osteoporosis*, Saturday, May 15, 11 a.m. - 5 p.m., Holiday Inn, Fort Smith  
*Sparks Tumor Conference*, Thursdays, 12:00 noon, Sparks Regional Medical Center  
*Tumor Conference*, Mondays, 12:00 noon, St. Edward Mercy Medical Center

#### **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernard's Regional Medical Center, Dietary Conference Room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Harris Hospital Tumor Conference*, 3rd Tuesday, 12:00 noon, Harris Hospital Conference Room  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Orthopedic Case Conference*, every other month beginning April 28, 7:30 a.m.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

#### **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

#### **TEXARKANA-AHEC SOUTHWEST**

*Chest Conference*, every other 3rd Wednesday, 12:30 p.m., St. Michael Hospital  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Residency Noon Conference*, Tuesdays, Wednesdays and Thursdays, 12:30 p.m., AHEC-Southwest Family Practice Clinic  
*Tumor Board*, Fridays, except 5th Friday, 12:00 noon, Wadley Regional Medical Center & St. Michael Hospital  
*Tumor Conference*, every 5th Friday, 12:00 noon alternates between Wadley Regional Medical Center & St. Michael Hospital

# The Journal of the Arkansas Medical Society

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